

DISABILITY APPLICATION FOR OPTION CHANGE INSTRUCTIONS - READ CAREFULLY

This application may only be used to change the retirement option of a member who retired under a Disability Option 2, or Option 3 when the original designated survivor predeceases you, you are awarded a divorce, or you marry after the date of your previous option election.

READ THESE INSTRUCTIONS AND THE DISABILITY OPTION CHANGE COUNSELING CHECKLIST COMPLETELY - ONCE FILED WITH SERS, YOUR ELECTION ON THIS APPLICATION IS FINAL AND BINDING AND MAY NOT BE CHANGED EXCEPT FOR THE REASONS LISTED ABOVE.

GENERAL

All information on your application forms should be typed or legibly printed in black ink. Signatures, where required, should be in black ink. When forms contain mistakes or alterations, SERS may not honor them, therefore we recommend that you complete a new form.

If your designated survivor has predeceased you, there will be NO DEATH BENEFIT payable on your account until you elect a new payment plan by completing and filing a new Disability Application for Option Change. The "Decedents, Estates, and Fiduciaries Code states that if you are awarded a divorce and you are domiciled in this Commonwealth, the survivor benefit will become ineffective. Your former spouse may still receive a survivor benefit if a court order or a Disability Application for Option Change filed after the date of divorce, so states.

If you chose to receive your monthly retirement benefit under a New Maximum Disability, you cannot designate your beneficiary(ies) on this application. You should complete a SERS-403 Beneficiary Nomination form and attach the form to this application.

RETIRED MEMBER INFORMATION

Insert your full name and Social Security number in the spaces provided. Also check the appropriate "Reason for Option Change", block.

PART A MONTHLY PAYMENT PLANS

To elect a new option you should select one of the monthly payment plans. Sign and date **ONLY** the plan you want to elect.

PART B DESIGNATED SURVIVOR ANNUITANT INFORMATION (Disability Options 2, or 3)

Complete this section ONLY if you elected to receive your monthly retirement benefits under Disability Option 2, or 3. If you elect Maximum Disability, leave this section blank.

List Designated Survivor Annuitants using their first or given name. For example: Jane Smith, NOT Mrs. William Smith. The Designated Survivor Annuitant may not be changed after you file a Disability Application for Option Change except in the case of death, or your divorce, or marriage. In such case, contact your SERS Regional Counseling Center immediately for further information.

You MUST submit a satisfactory proof of DATE OF BIRTH documentation for your Designated Survivor Annuitant with this application. A certified copy of either a BIRTH CERTIFICATE or BAPTISMAL CERTIFICATE is preferred. In neither is available, CERTIFIED copies of any TWO of the following may be substituted, listed in order of preference.

- | | | |
|------------------------------|--|--|
| 1 - Selective Service Record | 6 - Naturalization Record | 10 - Federal Census Record (taken as close to age 5 as possible) |
| 2 - Armed Forces Discharge | 7 - Alien Registration Record | 11 - Physician's or Midwife's record or birth |
| 3 - Passport | 8 - Marriage Record listing birthdate or age, and date of the record | 12 - Valid Pennsylvania Driver's License |
| 4 - School Record | 9 - Letter from Social Security verifying age | 13 - Bible or other Family Record |
| 5 - Life Insurance Policy | | |

PART C CERTIFICATION

Carefully read the certification statement before signing and dating your application. Remember, once this form is completed and filed with SERS, your elections are final and binding. **Two persons should sign this application as witnesses to your signature.**

1. INSTRUCTIONS



COMMONWEALTH OF PENNSYLVANIA
STATE EMPLOYEES' RETIREMENT SYSTEM

TOLLFREE: 1-800-633-5461
 www.sers.state.pa.us



REGION

◆ **DISABILITY APPLICATION FOR OPTION CHANGE** ◆

SS# _____

RETIRED MEMBER INFORMATION

NAME:	FIRST	MIDDLE	LAST	REASON:	<input type="checkbox"/> DEATH
					<input type="checkbox"/> DIVORCE <input type="checkbox"/> MARRIAGE

PART A MONTHLY PAYMENT PLANS - COMPLETE ONLY ONE PLAN

MAXIMUM DISABILITY OPTION

I UNDERSTAND THAT UNDER THIS PLAN I WILL RECEIVE THE MAXIMUM DISABILITY ALLOWANCE. IN ADDITION TO THE MAXIMUM DISABILITY ALLOWANCE, A VALUE IS PLACED ON MY RETIREMENT, CALLED THE "PRESENT VALUE". ALL PAYMENTS TO ME ARE SUBTRACTED FROM THE PRESENT VALUE AND ANY BALANCE REMAINING AT MY DEATH WILL BE PAID TO MY BENEFICIARY(IES). I MAY NAME ONE OR MORE BENEFICIARIES AT ANY TIME BY COMPLETING A SERS-403 BENEFICIARY NOMINATION FORM.

Signature: _____ Date: _____

DISABILITY OPTION 2

I UNDERSTAND THAT UNDER THIS PLAN I WILL RECEIVE A REDUCED DISABILITY RETIREMENT ALLOWANCE, WHICH IS COMPOSED OF TWO PARTS: AN EARLY RETIREMENT PORTION AND THE DISABILITY SUPPLEMENT. THE AMOUNT OF REDUCTION IS BASED ON THE SEX AND AGE OF MYSELF AND THE PERSON I NAME AS MY "DESIGNATED SURVIVOR ANNUITANT" IN PART B OF THIS FORM. AT MY DEATH, THAT PERSON WILL RECEIVE FOR LIFE THE SAME EARLY RETIREMENT BENEFIT I WAS ELIGIBLE TO RECEIVE PRIOR TO MY DEATH, LESS ANY NON-TRANSFERABLE PARTS OF THE COST OF LIVING ALLOWANCES I MAY BE RECEIVING.

Signature _____ Date _____

DISABILITY OPTION 3

I UNDERSTAND THAT UNDER THIS PLAN I WILL RECEIVE A REDUCED DISABILITY RETIREMENT ALLOWANCE, WHICH IS COMPOSED OF TWO PARTS: AN EARLY RETIREMENT PORTION AND THE DISABILITY SUPPLEMENT. THE AMOUNT OF REDUCTION IS BASED ON THE SEX AND AGE OF MYSELF AND THE PERSON I NAME AS MY "DESIGNATED SURVIVOR ANNUITANT" IN PART B OF THIS FORM. AT MY DEATH, THAT PERSON WILL RECEIVE FOR LIFE, HALF OF THE EARLY RETIREMENT BENEFIT I WAS ELIGIBLE TO RECEIVE PRIOR TO MY DEATH, LESS ANY NON-TRANSFERABLE PARTS OF THE COST OF LIVING ALLOWANCES I MAY BE RECEIVING.

Signature _____ Date _____

PART B DESIGNATED SURVIVOR ANNUITANT INFORMATION (FOR DISABILITY OPTIONS 2 OR 3)

FULL NAME	Date of Birth	Sex	Social Security Number
	/ /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	- -

Address (street, city, state, zip code)	Relationship
	<input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER

PART C CERTIFICATION

I, _____, HEREBY MAKE THE FOLLOWING CERTIFICATION:
 HAVING READ AND UNDERSTOOD ALL OF THE PRECEDING PROVISIONS, I UNDERSTAND THAT THE RETIREMENT OPTION PLAN SELECTION I MADE ON THIS APPLICATION IS FINAL AND BINDING, AND I HEREBY DECLARE THAT I INTEND TO BE LEGALLY BOUND BY THIS ELECTION. I ALSO UNDERSTAND THAT I MAY BE REQUIRED TO REPORT EARNINGS ON A CONTINUING BASIS AND TO PROVIDE MEDICAL EVIDENCE OF DISABILITY TO THE STATE EMPLOYEES' RETIREMENT SYSTEM AS REQUIRED. I THEREFORE AUTHORIZE AND PERMIT THE STATE EMPLOYEES' RETIREMENT SYSTEM TO MAKE DIRECT CONTACT WITH ANY OR ALL DOCTORS WHO MAY HAVE SUBMITTED MEDICAL REPORTS ON MY BEHALF. I ALSO UNDERSTAND THAT ANY WILLFUL FALSIFICATION OR FAILURE TO PROVIDE THE INFORMATION REQUIRED, MAY RESULT IN THE FORFEITURE OF MY RIGHTS TO FUTURE BENEFITS BASED ON SUCH INFORMATION AND SUCH OTHER PENALTIES AS PROVIDED BY LAW.

_____ Date

TWO PERSONS MUST WITNESS YOUR SIGNATURE.

WITNESS SIGNATURE:	WITNESS SIGNATURE:
ADDRESS	ADDRESS