* FILING FOR PROTECTION ONLY *

RET-54.1 (6/19)

NEW YORK STATE TEACHERS' RETIREMENT SYSTEM
10 Corporate Woods Drive, Albany, NY 12211-2395
Fax: (518) 431-8797

OFFICE SERVICES ONLY

APPLICATION FOR DISABILITY RETIREMENT

EmplID	OR	Social Security Number
		000 - 00 - 0000

Instructions: Write your EmplID or Social Security number in one of the boxes above. Print clearly in ink or type the requested information in the spaces provided. Please do not make any stray marks, but if you do, **please initial any changes you make**. On page 2, **sign this application and have it notarized**. Review the information and the checklist on page 6 before sending your application to the System. Submission of this application initiates a claim for any uncredited prior/military service and/or membership reinstatement. If you are filing for Tier 3-6 disability benefits, you must file an application no later than 12 months after the date that your employment status was terminated. You must have at least 10 years of NYS service credit to apply.

Member Name: John Doe

Mailing Address: 123 MAIN STREET

City: ANY TOWN | State: NY | Zip Code: 00000

Date of Birth			Phone Number	Email Address	Gender
1 Month	1 Day	75 Year	(631) 555-5555	JDoe@YAHOO.com	M

I AM APPLYING FOR DISABILITY RETIREMENT DUE TO THE FOLLOWING ILLNESS OR CONDITION (briefly describe):

SURGERY

If you are critically ill and wish to provide the largest lump sum payment to your beneficiary, you should elect the Largest Non-Declining Lump Sum Payment to a Beneficiary ***(All Tiers except Tier 3 members retiring under Article 14)*** *or the Declining Reserve 4%* ***(Tier 1 members only)*** *in the Retirement Benefit Election portion on the next page.*

- Were you on a leave of absence at less than full pay during the last seven years? Yes ☐ No ☑
- Are you being paid Workers' Compensation or Long-Term Disability? Yes ☐ No ☑
  If **YES**, are the payments being made directly through your employer's payroll? Yes ☐ No ☐

If you are receiving Workers' Compensation or Long-Term Disability paid through your employer's payroll, your date of retirement will be the date of your approval or your requested Date of Retirement, whichever is later.

If you would like to request a future date of retirement, please indicate the date: _____

It is not necessary to request a date of retirement as your effective date of retirement can be as early as the date this application is received. If you are still earning regular salary with your employer, your retirement will take effect the day following the last day salary was earned.

- Are you a member of, or retired from, any other New York State public retirement system? Yes ☐ No ☑

  If **YES**, name the retirement system: _____

Annuity Savings Fund (ASF) Withdrawal (Tier 1 & 2 Members Only)	☐	Please check this box if you have an Annuity Savings Fund and wish to withdraw it. We will send you additional information and any necessary forms.

Do you have any unclaimed service that has not been reflected on your *Benefit Profile*? If so, please provide school year(s) and employer(s). It is necessary for you to provide verification of this service. Verification forms are available on our website (NYSTRS.org).

No

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RETIREMENT BENEFIT ELECTION

Please review the option descriptions on pages 3-4 and **CHECK ONE BOX BELOW** for the form of benefit you want.

☐ **Maximum** - Do *not* designate a beneficiary if you select this option.

Lump Sum Options	Guarantee Options	Survivor Options*	Pop-up Survivor Options*
☐ Annuity Reserve (Tier 1 & 2 only)	☐ 5 Year	☐ 100% ☐ 50%	☐ 100% ☐ 50%
☐ Declining Reserve 4% (Tier 1 only)	☐ 10 Year	☐ 75% ☐ 25%	☐ 75% ☐ 25%

☒ **Largest Non-Declining Lump Sum Payment to a Beneficiary** (Tier 1 members should note that the beneficiary payment under this option is less than the initial payment under the Declining Reserve 4%. However, this option provides the largest *fixed* lump sum payment **to your beneficiary(ies)**.)

☐ **Alternative Option*** - Please provide a specific description:

*Per the Internal Revenue Code, the percentage available under a Survivor option or Pop-Up Survivor option may be limited when the beneficiary named is not the member's spouse and the beneficiary is more than 10 years younger than the member.

BENEFICIARY DESIGNATION

♦ **Complete this section if you choose an option other than Maximum election** ***(see information on pages 3-4)*** ♦

BENEFICIARY INFORMATION

Name JANE DOE	Check One ☒ Primary ☐ Contingent	Check One ☐ Male ☐ Female	Date of Birth 1/2/75
Street 123 MAIN ST			Beneficiary's Social Security # 000-11-0000
City, State, Zip ANY TOWN NY 11111	Relationship		
Name	Check One ☐ Primary ☐ Contingent	Check One ☐ Male ☐ Female	Date of Birth
Street			Beneficiary's Social Security #
City, State, Zip	Relationship		
Name	Check One ☐ Primary ☐ Contingent	Check One ☐ Male ☐ Female	Date of Birth
Street			Beneficiary's Social Security #
City, State, Zip	Relationship		
Name	Check One ☐ Primary ☐ Contingent	Check One ☐ Male ☐ Female	Date of Birth
Street			Beneficiary's Social Security #
City, State, Zip	Relationship		

** *This form must be signed and acknowledged before a Notary Public in order to be valid* **

Signature of Member John Doe

State of _____, County of _____ On this _____ day of _____, 20____

before me the undersigned, personally appeared _____
(Print Applicant's Name)

personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Printed Name of Notary: _____

Signature of Notary: _____ _____
Affix Stamp *(include expiration date)*

* MUST BE SIGNED + NOTARIZED / MAILED OR FAXED PRIOR TO MEMBER PASSING AWAY

RET-54.1B (6/12)

OFFICE SERVICES ONLY

NEW YORK STATE TEACHERS' RETIREMENT SYSTEM
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MEDICAL INFORMATION SUMMARY

COMPLETE AND RETURN WITH YOUR RETIREMENT APPLICATION

AUTHORIZATION

EmplID: _____

I hereby authorize and direct any physician, hospital, medical records facility or any other party to disclose to the New York State Teachers' Retirement System all information which they may possess including, but not limited to, diagnosis, treatments rendered, x-rays and copies of all hospital and medical records which are in their possession, and further, I waive any claim of privilege in respect thereto. A photocopy of this authorization shall be considered as effective and valid as the original.

Print Name: John Doe

Signature of Applicant: John Doe

IMPORTANT: The authorization above must be signed

A. Please list the names, addresses and telephone numbers of the physicians consulted in connection with your illness from whom we should expect a report*:

Names and Addresses	Phone and FAX Numbers

It is your responsibility to give a medical report form to each of the physicians named

B. Briefly describe your illness and symptoms (If more room is needed, please use reverse side)

_____

_____

_____

_____

_____

C. On what date did you become incapacitated? _____

D. What was the last date you rendered service? _____

E. What subject area and grade level was your last teaching position? _____

_____

F. Do you work in any other capacity? ☐ No ☐ Yes
If yes, please explain. _____

_____

Complete EACH ITEM