RET-54.1 (6/19)

OFFICE SERVICES ONLY

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

APPLICATION FOR DISABILITY RETIREMENT

EmplID	*OR*	Social Security Number

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					
Mailing Address					
City			State	Zip Code	
Date of Birth			Phone Number	Email Address	Gender
Month	Day	Year	( )		

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

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).

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	*Check One* Primary ☐	*Check One* Male ☐	Date of Birth
Street	Contingent ☐	Female ☐	Beneficiary's Social Security #
City, State, Zip	Relationship		
Name	*Check One* Primary ☐	*Check One* Male ☐	Date of Birth
Street	Contingent ☐	Female ☐	Beneficiary's Social Security #
City, State, Zip	Relationship		
Name	*Check One* Primary ☐	*Check One* Male ☐	Date of Birth
Street	Contingent ☐	Female ☐	Beneficiary's Social Security #
City, State, Zip	Relationship		
Name	*Check One* Primary ☐	*Check One* Male ☐	Date of Birth
Street	Contingent ☐	Female ☐	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

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)***

DESCRIPTION OF MAXIMUM AND OPTIONAL BENEFITS

The retirement benefits from this System are annual, lifetime payments to the members. We must receive any change in your option election within 30 days after the date your retirement becomes effective. If you do not make an election, you will be retired under the Maximum.

Maximum

This election will provide you with the largest possible annual benefit. The maximum benefit does not provide a payment to a beneficiary. All payments will cease at your death.

Lump Sum Options — You may designate ***multiple*** primary and/or contingent beneficiaries under these options.

Annuity Reserve — This option is only available to Tier 1 or Tier 2 members who do not withdraw their Annuity Savings Fund (ASF) at retirement. The Annuity Reserve is the total in your ASF at retirement. If your death occurs ***before*** the Total Reserve has been paid, the balance will be paid in a lump sum to your beneficiary. If death occurs ***after*** the Annuity Reserve has been paid, all payments will cease at your death.

Declining Reserve 4% — This option is only available to Tier 1 members. The Total Reserve is the pension reserve established at the time of your retirement plus the balance in your Annuity Savings Fund, if any. If your death occurs ***before*** the Total Reserve has been paid, the balance will be paid in a lump sum to your beneficiary. If death occurs ***after*** the Total Reserve has been paid, all payments will cease at your death. There is a variation of this option based on a 7% interest rate that would result in a smaller Total Reserve but a larger monthly payment; please contact us if this interests you.

Largest Lump Sum — This option will provide all members with the ***largest possible*** lump sum **payment to a beneficiary**. Tier 1 members should note that although the payment to a beneficiary under this option will be less than the Total Reserve initially established under the Declining Reserve 4% option, the lump sum payment under this option does not decrease over time. **This option is not available to Tier 3 members retiring under Article 14.**

Your estimate provides you with the largest lump sum payment to your beneficiary. The "Cost per $1000" indicated on your estimate will allow you to calculate your benefit should you desire a fixed lump sum payment of a lesser amount to your beneficiary. If you desire a lesser lump sum payment to your beneficiary, you should select the Alternative Option on the retirement application and indicate the lump sum payment desired. The following example will help you calculate the effect a lesser lump sum payment will have on your retirement benefit.

Example: Your Annual Maximum Benefit is $60,000; your "Cost per $1000" is $25; you want to provide a $20,000 lump sum payment to your beneficiary.

20 (increments of $1000 needed) x $25 ("Cost per $1000") = $500 Annual Cost of the Coverage

$60,000 (Maximum Benefit) minus $500 (Cost of Coverage) = $59,500 Optional Member Benefit

Guarantee Options — You must designate only ***one*** primary beneficiary. **Multiple** contingent beneficiaries are allowed.

If you predecease your beneficiary within 5 or 10 years of the date of your retirement, your beneficiary will receive the same monthly payment you were receiving for the remainder of the 5 or 10 year period. If you live beyond the 5 or 10 year guaranteed period, your benefit will cease at your death. **If your primary beneficiary begins to receive payments and dies before the 5 or 10 year guaranteed period expires, the commuted value of any installments due will be paid in a lump sum to your contingent beneficiary.**

Survivor Option and Pop-up — You may designate only ***one*** beneficiary under these options.

If your beneficiary survives you, he or she will receive the designated percentage of your reduced benefit throughout his or her lifetime. You must provide proof of date of birth for your beneficiary. **Under the Pop-up Option your benefit will increase to the Maximum if your beneficiary predeceases you. Your beneficiary designation may not be changed after 30 days after your date of retirement. The 25% and 75% pop-up options are not available to Tier 3 members electing to retire under Article 14.**

*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.

Alternative Option

Tier 3 members electing to retire under Article 14 may only request an Alternative Option that provides a survivor option of 1% to 90% at their death. All other members may request ***any variation*** of a lump sum, guarantee, survivor or pop-up option that is reasonable and can be computed actuarially.

Beneficiaries of Tier 2-6 members who elected the **In-Service Paragraph 2 Death Benefit** upon joining NYSTRS may be entitled to receive a **lump sum payment** after retirement. The lump sum payment would be in addition to any payments made as a result of an Optional Benefit selection. Please refer to the *Active Members' Handbook* and your *Benefit Profile* for additional information.

DISABILITY RETIREMENT INFORMATION

Filing Information

If you apply for disability retirement, you must provide proof the disability existed at the time you ceased teaching in a NYS public school. The Retirement Board may require you to be examined by a physician chosen by the Board. Refusal to submit to the required examination will result in disapproval or discontinuance of your disability retirement.

Your application must be received by the Retirement System on or before your requested date of retirement. If the System receives your *Application for Disability Retirement* by certified or registered U.S. mail, the System will consider it received on the date it was postmarked. You should retain proof that your application was sent to the System for your records.

We will process your application and the option payment will be made if:

- You die before the effective date of retirement, ***and***
- You selected either the Declining Reserve 4% (for a Tier 1 member) or the Largest Non-Declining Lump Sum Payment to a Beneficiary, ***and***
- You otherwise qualify for disability retirement, ***and***
- The Retirement Board determines the illness specified in your application is related to the cause of your death.

Contributions

If you are a Tier 1 or 2 member, you may withdraw the balance of your Annuity Savings Fund (ASF), if any, in lieu of receiving a monthly annuity. To withdraw these funds, please check the box on page 1 of this application. We will deduct any outstanding loan balance from your ASF.

Cancellation or Retirement Date Change

If you wish to cancel your application for retirement or change the date your retirement will commence, you should send us a signed letter indicating your desire to cancel your retirement or change your retirement date. This letter must be received by the System ***prior to*** the date your retirement would have occurred.

Death Benefit for Tier 2 – 6 Members

For those members who are eligible for the Paragraph 2 death benefit coverage, a separate post-retirement benefit may be payable to the designated beneficiary. To be eligible for this benefit, you ***must*** meet the eligibility requirements of the in-service death benefit on the day before retirement takes effect.

Membership Reinstatement

If you held an earlier date of membership in ***any*** NYS public retirement system, your current membership may be reinstated to the earlier date. **Tier 3 – 6 members reinstating to Tier 1 or 2 must repay any outstanding loan balance before their date of retirement.** If you feel you may benefit from membership reinstatement, you must advise us in writing immediately.

Accelerated Death Benefit

Under certain conditions members may be eligible to forfeit their disability retirement in lieu of a lump sum payment equal to their pre-retirement death benefit. Please advise us immediately if you are interested.

Loan Payments

If it is your intent to repay all or a portion of any outstanding loan prior to retirement, NYSTRS must receive the payment prior to the effective date of retirement. Any payments received after the date **will not** be credited to the outstanding loan balance.

Filing for Protection

Filing "For Protection Only" simply means that, in doing so, you are protecting the benefit for your beneficiary(ies) in the event of your death.

If you are filing for protection, when you fill out the *Application for Disability Retirement* (RET-54.1):

- Write the words "For Protection Only" at the top of the form.
- Indicate the nature of your disability.
- Do NOT request a date of retirement.
- Choose the Largest Non-Declining Lump Sum as your retirement option and designate a beneficiary.
- Complete and return the *Medical Information Summary* (RET-54.1B).

Your "For Protection Only" benefit will be paid only if you pass as a result of the illness listed on your application/Medical Summary.

While your application remains on file "For Protection" the option selection must remain the Largest Non-Declining Lump Sum. If you have filed "For Protection Only" and then at a later date decide to pursue disability retirement, you must notify us in writing you wish to continue with your disability retirement application. Once you are approved by the Retirement Board, you will have 30 days from the effective date of retirement to change your retirement option to the option of your choice.

DISABILITY RETIREMENT INFORMATION *Cont.*

You and your physicians play a vital role during the processing of your application. Our Medical Board requires evidence of the extent of your disability. You have the burden of providing such evidence. We are enclosing forms that will assist you in meeting this requirement.

- **MEDICAL INFORMATION SUMMARY (RET-54.1B)** - Please complete this form and return it directly to us. ***Be sure to sign the authorization.***

- **MEDICAL REPORT (RET-54.3)** - Complete Part 1 of this form(s) and give one to each physician involved in your care as soon as possible. ***In addition to the form,*** they must provide us with:

  - a comprehensive record of the history of your illness;
  - copies of diagnostic test results, including X-ray, MRI and CAT scan reports;
  - any surgical or pathology reports; and,
  - a detailed narrative report of the current status of your health.

Please remind your doctors of these requirements. Incomplete information will delay processing your application.

Once we receive your medical records, we will present your file at the monthly meeting of our Medical Board. If the Medical Board recommends approval, we will then present your file to the Retirement Board for consideration. The Medical Board has the authority to recommend that you be examined by a physician appointed by the System. Failure to submit to an exam will provide an independent basis to deny or discontinue benefits.

As you can see, there are many phases to the disability retirement process. Even though we will make every effort to expedite the processing of your application, delays may occur, and you should plan your finances accordingly. If you have any questions or you need additional forms, please call our Disability Unit at (800) 348-7298, Ext. 6010.

Retirement Application Package Checklist

- ❒ Did you indicate your illness or condition in the box in the middle of page 1?
- ❒ If you are critically ill, did you choose the appropriate option on page 2?
- ❒ If you are a Tier 1 or 2 member, did you indicate on page 1 if you wish to withdraw your annuity?
- ❒ Did you initial any changes you may have made?
- ❒ Is your retirement application signed and notarized on page 2?
- ❒ Did you sign and date the withholding form on page 15 and the direct deposit form on page 17?
- ❒ Did you include the Medical Information Summary (page 7) and mail the Medical Report form(s) to your doctor(s)?
- ❒ Did you write your EmplID or Social Security number in the appropriate box on page 1?
- ❒ Did you write your EmplID and Social Security number in the appropriate boxes on pages 15 and 17?

Please call us at (800) 348-7298, Ext. 6010 if you need help completing this application.

OFFICE SERVICES ONLY

NEW YORK STATE TEACHERS' RETIREMENT SYSTEM
10 Corporate Woods Drive, Albany New York 12211-2395

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: _____

Signature of Applicant: _____

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. _____

_____

MEDICAL INFORMATION SUMMARY

Additional space, if needed

RET-54.3 (5/19)

OFFICE SERVICES ONLY

NEW YORK STATE TEACHERS' RETIREMENT SYSTEM
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(800) 348-7298, Ext. 6010; Fax (518) 431-8797

MEDICAL REPORT

PART 1 (To Member): This section must be completed by you and forwarded to your physician.

Patient's Name and Address	EmplID or Social Security Number	Date of Birth

Physician's Name	Physician's Address

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.

Signature of Applicant: _____ Date_____

PART 2 (To Physician): **Your patient applied for disability retirement from this System. *Benefits will not be granted until we receive complete documentation of the person's illness. Please initial any alterations made during the completion of this form.***

Please provide copies of any surgical or pathology reports, diagnostic test results (including X-ray, MRI, and CAT scan reports), psychological and neurological evaluations, and any reports and progress notes that clearly outline the history of the person's illness.

Date you first treated this patient: _____

Date the disability began: _____

Date you last saw this patient: _____

Is this patient **totally**** disabled from the performance of <u>all</u> gainful employment? ☐ Yes ☐ No

Please explain why: _____

_____

_____

Is this patient **permanently**** disabled from the performance of <u>all</u> gainful employment? ☐ Yes ☐ No

Please explain why: _____

_____

_____

Physician's Specialty, if any: _____ Date of Board Certification: _____

Physician's Name (Printed): _____

Physician's Signature: _____ Date: _____

****SEE PART 3 FOR NARRATIVE AND STANDARDS****

PART 3 (To Physician): Provide a narrative description of the person's illness including:

- **a history**
- **treatment received and the result**
- **diagnosis**
- **prognosis**

Please type or print clearly

STANDARD FOR DETERMINING DISABILITY RETIREMENT

- In order for a member to be entitled to disability retirement, it must be determined that the member is totally and permanently disabled and that member was so disabled at the time he or she ceased performance of duties.
- **To be deemed totally disabled** it must be concluded that the member is physically or mentally incapacitated from the performance of gainful employment. Gainful employment shall be physical and/or mental activity which a member is regularly able to engage in as a means of earning a living.
- **To be deemed permanently disabled**, the condition must be such to justify a deduction that the end of the disability cannot be foreseen for at least one year. In addition, total disability is not permanent if, during the period for which recovery is sought or at any time thereafter, the member may alleviate or control the condition by availing himself or herself of a standard treatment which is not inherently dangerous.
- The member shall have the burden of establishing all of the foregoing to the satisfaction of the Retirement Board.

Physician's Specialty, if any: _____ Date of Board Certification: _____

Physician's Name (Printed): _____

Physician's Signature: _____ Date: _____

RET-54.3 (5/19)

OFFICE SERVICES ONLY

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PART 1 (To Member): This section must be completed by you and forwarded to your physician.

Patient's Name and Address	EmplID or Social Security Number	Date of Birth

Physician's Name	Physician's Address

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.

Signature of Applicant: _____ Date_____

PART 2 (To Physician): **Your patient applied for disability retirement from this System. *Benefits will not be granted until we receive complete documentation of the person's illness. Please initial any alterations made during the completion of this form.***

Please provide copies of any surgical or pathology reports, diagnostic test results (including X-ray, MRI, and CAT scan reports), psychological and neurological evaluations, and any reports and progress notes that clearly outline the history of the person's illness.

Date you first treated this patient: _____

Date the disability began: _____

Date you last saw this patient: _____

Is this patient **totally**** disabled from the performance of <u>all</u> gainful employment? ☐ Yes ☐ No

Please explain why: _____

_____

_____

Is this patient **permanently**** disabled from the performance of <u>all</u> gainful employment? ☐ Yes ☐ No

Please explain why: _____

_____

_____

Physician's Specialty, if any: _____ Date of Board Certification: _____

Physician's Name (Printed): _____

Physician's Signature: _____ Date: _____

****SEE PART 3 FOR NARRATIVE AND STANDARDS****

PART 3 (To Physician): Provide a narrative description of the person's illness including:

- **a history**
- **treatment received and the result**
- **diagnosis**
- **prognosis**

Please type or print clearly

STANDARD FOR DETERMINING DISABILITY RETIREMENT

- In order for a member to be entitled to disability retirement, it must be determined that the member is totally and permanently disabled and that member was so disabled at the time he or she ceased performance of duties.
- **To be deemed totally disabled** it must be concluded that the member is physically or mentally incapacitated from the performance of gainful employment. Gainful employment shall be physical and/or mental activity which a member is regularly able to engage in as a means of earning a living.
- **To be deemed permanently disabled**, the condition must be such to justify a deduction that the end of the disability cannot be foreseen for at least one year. In addition, total disability is not permanent if, during the period for which recovery is sought or at any time thereafter, the member may alleviate or control the condition by availing himself or herself of a standard treatment which is not inherently dangerous.
- The member shall have the burden of establishing all of the foregoing to the satisfaction of the Retirement Board.

Physician's Specialty, if any: _____ Date of Board Certification: _____

Physician's Name (Printed): _____

Physician's Signature: _____ Date: _____

RET-54.3 (5/19)

OFFICE SERVICES ONLY

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(800) 348-7298, Ext. 6010; Fax (518) 431-8797

MEDICAL REPORT

PART 1 (To Member): This section must be completed by you and forwarded to your physician.

Patient's Name and Address	EmplID or Social Security Number	Date of Birth

Physician's Name	Physician's Address

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.

Signature of Applicant: _____ Date_____

PART 2 (To Physician): **Your patient applied for disability retirement from this System. *Benefits will not be granted until we receive complete documentation of the person's illness. Please initial any alterations made during the completion of this form.***

Please provide copies of any surgical or pathology reports, diagnostic test results (including X-ray, MRI, and CAT scan reports), psychological and neurological evaluations, and any reports and progress notes that clearly outline the history of the person's illness.

Date you first treated this patient: _____

Date the disability began: _____

Date you last saw this patient: _____

Is this patient **totally**** disabled from the performance of <u>all</u> gainful employment? ☐ Yes ☐ No

Please explain why: _____

_____

_____

Is this patient **permanently**** disabled from the performance of <u>all</u> gainful employment? ☐ Yes ☐ No

Please explain why: _____

_____

_____

Physician's Specialty, if any: _____ Date of Board Certification: _____

Physician's Name (Printed): _____

Physician's Signature: _____ Date: _____

****SEE PART 3 FOR NARRATIVE AND STANDARDS****

PART 3 (To Physician): Provide a narrative description of the person's illness including:

- **a history**
- **treatment received and the result**
- **diagnosis**
- **prognosis**

Please type or print clearly

STANDARD FOR DETERMINING DISABILITY RETIREMENT

- In order for a member to be entitled to disability retirement, it must be determined that the member is totally and permanently disabled and that member was so disabled at the time he or she ceased performance of duties.
- **To be deemed totally disabled** it must be concluded that the member is physically or mentally incapacitated from the performance of gainful employment. Gainful employment shall be physical and/or mental activity which a member is regularly able to engage in as a means of earning a living.
- **To be deemed permanently disabled**, the condition must be such to justify a deduction that the end of the disability cannot be foreseen for at least one year. In addition, total disability is not permanent if, during the period for which recovery is sought or at any time thereafter, the member may alleviate or control the condition by availing himself or herself of a standard treatment which is not inherently dangerous.
- The member shall have the burden of establishing all of the foregoing to the satisfaction of the Retirement Board.

Physician's Specialty, if any: _____ Date of Board Certification: _____

Physician's Name (Printed): _____

Physician's Signature: _____ Date: _____

FIN-149 (1/19)

NEW YORK STATE TEACHERS' RETIREMENT SYSTEM
10 Corporate Woods Drive, Albany, NY 12211-2395
Fax: (518) 431-8783

OFFICE SERVICES ONLY

W-4P WITHHOLDING ELECTION AND CERTIFICATE

Please read the information on the reverse side and the instructions below before completing this form.

INSTRUCTIONS

Please print your full name, home address, EmplID, Social Security number, and phone number in the appropriate boxes. Use an "X" for check box indication.

If the address listed below is a change of your home address, check this box: ☐

EmplID

Social Security Number ___ – ___ – ____

First Name **MI** **Last Name**

Mailing Address - Line 1

Mailing Address - Line 2 ***(if needed)***

City **State** **Zip Code** – ____

Phone Number (___) ___ – ____

COMPLETE ONLY *ONE* SECTION; SIGN AND DATE ON THE LINE BELOW

Section 1

I DO NOT want to have federal income tax withheld from my monthly benefit. ☐

Do Not Complete Section 2 or 3

OR

Section 2

I want to have federal income tax withholding calculated using marital status and the number of exemptions claimed, **COMPLETE BOTH LINES A & B** in this section only. Complete Line C if applicable.

A. Marital Status *(Check One)*: Married ☐ Single/widow(er) ☐

B. Total Number of Exemptions Claimed: ☐

C. Additional Amount to be Withheld Monthly (optional): $ _____ . __

Do Not Complete Section 1 or 3

OR

Section 3

I want to have withheld a specific dollar amount of federal income tax from my monthly benefit. Percentages cannot be accepted.

TOTAL Fixed Dollar Amount to be Withheld Monthly: $ _____ . __

Do Not Complete Section 1 or 2

Signature

Date __ / __ / ____
Month Day Year

Generally, the Retirement System should receive the *W-4P Withholding Election and Certificate* by the twelfth of the month that you want your withholding amount to change.

If your monthly benefit payment is currently being sent via Direct Deposit, the filing of the W-4P will not affect that process, just the amount transmitted into your account.

Any election you make will remain in effect until you change it. You may change your election at any time by using the "Tools" feature in your online MyNYSTRS account at NYSTRS.org or by requesting and filing another *W-4P Withholding Election and Certificate*.

If you do not submit a W-4P form, the System must withhold as if you are married claiming three withholding allowances.

Even if you elect not to have federal income tax withheld, you are liable for payment of federal income tax on the taxable portion of your pension. Also, if you do not have sufficient federal income tax withheld, you may be responsible for payment of estimated taxes. It should be noted, you might incur penalties under the estimated tax rules if your withholding and/or estimated tax payments are not sufficient.

Any election you make should take into consideration all deductions that are being taken from your monthly payment. The specific amount chosen should not exceed the net amount of your monthly payment.

Please consult a tax expert or the Internal Revenue Service should you require additional information regarding your withholding election.

GRE-54 (8/19)

NEW YORK STATE TEACHERS' RETIREMENT SYSTEM
10 Corporate Woods Drive, Albany, NY 12211-2395
Fax: (518) 447-4749

OFFICE SERVICES ONLY

DIRECT DEPOSIT AUTHORIZATION AGREEMENT

Complete the information requested below and make a copy of this form for your records. If you are signing as a benefit recipient's Guardian or agent under a Power of Attorney, or need assistance completing this form, refer to the *Direct Deposit Authorization Fact Sheet* (GRE-54.1) on our website at NYSTRS.org.

☐ *Check this box if the direct deposit will go to a foreign bank or the entire amount will be forwarded from a domestic bank to a foreign bank.*

EmplID **Social Security Number** ___ – ___ – ____

Please indicate the type(s) of payments you wish to update with this form:

☐ Retiree ☐ Beneficiary of a retiree ☐ Alternate payee under a Domestic Relations Order

First Name **MI** **Last Name**

Mailing Address - Line 1

Mailing Address - Line 2 *(if needed)*

City **State** **Zip Code** –

Phone Number ( ) – **If this is a change of address, please give effective date:** / / (Month / Day / Year)

☐ Check this box if you are depositing your monthly benefit to an account titled to a trust that specifically meets the requirements detailed in *Instructions for Direct Deposit to Trust* (LEG-2) at NYSTRS.org. All required additional documentation must be received by the System to process your direct deposit.

The following information is used to transmit your payments directly to your bank account. The bank ABA/Routing Number is the 9 digits on the bottom of your check. If you have questions regarding your ABA/Routing Number or account number, refer to the *Direct Deposit Authorization Fact Sheet* (GRE-54.1) on our website at NYSTRS.org or contact your financial institution.

BANK NAME **BANK PHONE NUMBER** ( ) –

BANK ABA/ROUTING NUMBER (9 digits) **ACCOUNT NUMBER**

NAME ON ACCOUNT

ACCOUNT TYPE (Please check one) ☐ **CHECKING/MONEY MARKET** ☐ **SAVINGS**

I authorize NYSTRS to automatically deposit any benefit payable to me in the foregoing account, or in any future account hereafter communicated by me to NYSTRS in writing, which future account(s) shall be subject to the terms of this *Direct Deposit Authorization Agreement*. I understand that I may cancel this authorization by submitting written notification to NYSTRS.

I agree NYSTRS shall have no liability or responsibility for loss due to erroneous information supplied by myself or my duly authorized representative. I acknowledge and understand any payments made pursuant to this request will be strictly an accommodation made to me by NYSTRS. NYSTRS reserves the right to discontinue or decline to honor this EFT request without prior notice. I hereby authorize and direct the financial institution, on my behalf, my joint account holder or trustee, if any, or my estate to charge my account for amounts paid to which I was not entitled. I also agree, on behalf of myself, my joint account holder or trustee, if any, and my estate that such amounts will be returned to NYSTRS.

SIGNATURE **Month** / **Day** / **Year**