ERSGA
Employees' Retirement System of Georgia
Serving those who serve Georgia

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ers.ga.gov

Employees' Retirement System

Disability Retirement Application

The Retirement Process

ERSGA cannot accept the retirement application more than 90 days prior to the requested retirement date. The effective retirement date may not be less than 30 days after the completed application is filed. The application is considered filed only when ERSGA has received it and confirmed that the application is complete.

Incomplete applications will be returned to the member.

Retirement always begins on the first of a month. All retirement payments will be direct deposited on the last business day of each month.

Once you have submitted a Disability Retirement application, your Employer must offer you an alternative position, if available. The requirements for an alternative position are:

- The physical requirements are compatible with your physical limitations;
- The annual compensation and possibility for future advancement are the same or greater than your current position;
- The duties are reasonably compatible with your experience and educational qualifications;
- The position is covered under ERS; and
- The position is available and offered to you in writing no later than 45 days after your disability application is submitted.

If an alternative position is offered to you, you must, within 30 days of the offer, accept or dispute in writing your ability to perform in the alternate position by submitting a written appeal to both ERS and the employer.

The ERSGA Medical Board evaluate Disability Retirement applications to determine whether you are eligible for disability retirement based on your inability to perform the duties of your original position and, if applicable, an alternative position. If the Medical Board determines that you are capable of performing the duties of either position, the disability retirement application will be denied.

Application for Disability Retirement Checklist

It is your responsibility to submit the **complete** application packet (Parts I – V) to ERSGA.

Incomplete packets will be returned to the applicant and will not be processed.

Do **not** terminate employment before you receive confirmation from ERSGA that your completed application has been received and is being processed.

The following Checklist is provided to assist you in assuring that your packet is complete:

☐ Part I Retirement Application – Demographics, Option selection, Beneficiary designation

☐ Part II Employee's Disability Self-Report

☐ Part III Employer's Disability Report

☐ Part IV Physician's Report – A separate physician's report is required from each of your medical providers listed on page 6 of Part II

☐ Part V Current Detailed Job Description – Your employer must provide information detailing your normal job duties. You must provide a copy of this job description to all physicians and all medical providers

Employees' Retirement System

Disability Retirement Application

Part I

General Instructions

- This Monthly Retirement Application may be used only for the Employees' Retirement System (ERS).
- Please type or print. Blue ink is preferred.
- You will need to initial, write the last four numbers of your Social Security number, and date on pages 17, 18, 19, 20, 23, 24, and 25.
- Please note that page 21 will need to be completed and notarized.
- Your signature, the last four numbers of your Social Security number, and the date are needed on page 22.
- The IRS form on page 26 needs Section 1 completed and your signature and date in Section 5.
- Make a copy of the application and any attachments for your records.
- Return completed application forms directly to ERSGA.

Omitted or incomplete information will delay processing *(*see the check list on page 29).

Privacy Note
IRS regulations require ERSGA to obtain the social security number of any member before processing his or her election to retire. Disclosure is mandatory and this application will not be processed without this information.

Filing Your Application
This application is not considered filed until it is received by ERSGA.

Effective Retirement Dates
All retirement dates are effective on the first day of the month, upon approval of permanent disability by the ERS Medical Board and after your date of termination (or separation) upon meeting the service and/or age qualifications. Your effective retirement date must be at least 30 days after the completed application is received by our office. The first monthly retirement allowance is paid on either the last working day of the month in which your retirement effective date occurs or the next available payroll month.

The Board of Trustees and ERSGA developed this retirement application to provide general information about your retirement benefits. In the case of any conflict between what is presented here and the laws governing this System, the law will take precedence.

Service Retirement
This application is for disability retirement only. If you wish to apply for service retirement, please access our website at ers.ga.gov and Log In to your online account to "Apply for Retirement". You can also download an ERS Service Retirement Application from our website.

Disability Retirement Information

- **Note:** If your membership started before July 2007 and you are age 60 or older, Georgia Law states that you will receive a service retirement allowance. Please complete an ERS Service Retirement Application instead of an ERS Disability Retirement Application.
- **Note:** If your membership started on or after July 1, 2007, and are you age 60 or older or you have 30 or more years of service, Georgia Law states that you will receive a service retirement allowance. Please complete an ERS Service Retirement Application, instead of an ERS Disability Retirement Application.
- You must submit a complete disability packet including Parts I – V. **ERSGA will not accept incomplete packets. Note:** If you terminate employment before your disability application is received and accepted by ERSGA, you are not eligible for disability retirement
- To apply for disability retirement, you must be placed on leave status, either leave with pay or leave without pay. If you return to work, the disability retirement application is void.
- Your Employer must complete Parts III and V before you submit this application.
- You **must** provide your Employer with a **complete copy** of your application for disability retirement and **all supporting documentation** at the same time you file your application for disability retirement with ERSGA.
- As part of the disability process, your employer is required to offer an alternative position if available.
- If the ERSGA Medical Board is unable to make a decision based on the provided medical information, the Board may request an examination from an independent physician. ERSGA will pay for this examination.

Before Retirement

Purchasing Service
All service purchases must be completed prior to termination.

Terminating State Employment
After receiving your retirement application, ERSGA will contact your state employer for salary and forfeited leave information as well as the alternative position form. If your application is approved by the ERSGA Medical Board, you must terminate from state employment prior to the effective date of your retirement. You must not terminate employment before your **complete** disability retirement application packet is received and accepted by ERSGA.

Making Changes To This Application After Filed
Once you have filed a Retirement Application, any changes in the retirement allowance options, dates or beneficiaries listed in this application must be received by ERSGA in writing prior to the last business day of the effective month of retirement. Changes received less than 20 days prior to retirement may delay the issuance of your first payment. All retirement options are final when the first retirement allowance becomes due on the last business day of the effective retirement month or payroll month. After Retirement exceptions are specified in the options instructions of this form.

After Retirement

Post-Retirement Benefit Adjustment

- Post-Retirement Benefit Adjustments are subject to the approval of the ERS Board of Trustees
- A Post-Retirement Benefit Adjustment is not guaranteed and you should not base your financial decisions on the possibility of an increase until an increase has been announced
- Eligibility for Post-Retirement Benefit Adjustments is currently:
    - You must be retired for at least 12 months
    - If you retire under Early Retirement provisions, the Normal Retirement Date must be at least 12 months ago (Normal Retirement is the earlier of age 60 or the date you would have obtained 30 years of Creditable Service, whichever is earlier)
    - If you retire under Disability Retirement, you must be at least age 45 or older
- If your membership start date is on or after 7/1/2009, you are not eligible for a post-retirement increase

Making Changes

Retirement Options

Options cannot be changed on or after the day the first retirement allowance normally becomes due on the last business day of the effective retirement month or payroll month whichever is later, except in the specific cases listed below.

- If unmarried at retirement, upon marriage after retirement the retiree may change to an actuarially recalculated optional benefit naming the new spouse as primary beneficiary; however:
    1. If retired under the Maximum Plan, this election must be made in writing within six months after the marriage.
    2. If retired under an optional allowance, the retiree must revoke the original option and elect, in writing, option 2, 3, 4, 5A, or 5B with the new spouse as primary beneficiary at any time after the marriage.
- If married at retirement and retired under an optional allowance (option 2, 3, 4, 5A, or 5B) with the spouse listed as the sole primary beneficiary, and divorce occurs, the following applies:
    1. The retiree may elect to change to the Maximum Plan or may leave the divorced spouse as beneficiary under the existing option.
    2. If the option has been changed to the Maximum Plan, after one year of re-marriage, or the birth of a child from that marriage, the retiree may re-elect the original retirement option actuarially recalculated with the new spouse as sole primary beneficiary.

Beneficiaries

- Primary Retirement Beneficiary(ies)
    - If you chose the Maximum Plan, Option 1, 4 Period Certain, or 4 Accelerated benefit at retirement, you may change your Primary Beneficiary(ies) at any time.
    - If you chose the Option 2, 3, 4 Flat Amount to Beneficiary, 4 Max Amount to Beneficiary, 5A or 5B at retirement, the right to change your Primary Beneficiary is limited.
- Secondary Beneficiary(ies) – Secondary Beneficiaries may be changed at any time, regardless of your retirement option.
- Group Term Life Insurance – Both Primary and Secondary Beneficiaries may be changed at any time.
- Allowable beneficiary changes take effect when ERSGA receives the changes in writing with an original signature. You can download the Retiree's Change of Beneficiary form from our website: ers.ga.gov.

Addresses and Taxes

Changes for your address, federal taxes, and state of Georgia taxes can be made at any time. Changes received in the ERSGA office by the 18th of the month should be reflected on that month's payment. Changes can be made online by logging in to your account at ers.ga.gov or by downloading the address change, federal tax, and state of Georgia tax withholding forms from our website: ers.ga.gov.

Direct Deposit

Direct deposit is mandatory and should begin with your first monthly benefit payment. You can make changes online by logging in to your account at ers.ga.gov or download the direct deposit form from our website: ers.ga.gov.

Disability Retirement Application Form – Page 16

Name
Please print/type your name as you would like it to appear on your retirement check.

Date of Birth and Social Security Number
Any discrepancies must be resolved prior to any payment of benefits.

Mailing Address
Please print or type the mailing address where you would like us to mail important retirement documents and correspondence.

Email Address
Please print or type your personal email address.

Home and Cell Phone Numbers
Please print or type your home phone number or cell phone number, or the best day-time contact number.

Marital Status
Please check the box in front of your current marital status.

State Employer
Please print or type the name of your current employer or last state employer.

Position Title
Please print or type your current title or last state position title.

Effective Date of Retirement
Your effective retirement date will always be on the first day of the month. For example: If your last day of employment is in May, your retirement date will be June 1.

Type of Retirement
Under both of the following types you must be an active ERS member*

- at the time you become disabled, **and**
- when your complete disability retirement application and packet is received and accepted by ERSGA.

** You will not be eligible if you terminate from employment before your complete disability application is received and accepted by ERSGA*.

Disability

- Unable to perform your job or any offered alternative position due to a permanent medical condition(s); and;
- Have attained the minimum years of service, as follows:
    - For Old Plan and New Plan Members: at least 13 years and 4 months of Creditable Service;
    - For GSEPS Members: at least 15 years of Creditable Service.

Injury in Line of Duty

- Open to certain law enforcement officers only (see your personnel office)
- Must be unable to perform your job due to a permanent medical condition incurred in the line of duty

Retirement Options Form - Page 17

Maximum Plan
This option provides the highest, lifetime monthly benefit to you. No monthly benefit is payable after death. At your death, your named beneficiary(ies) will receive a single payment of any funds remaining in your contributions and interest account. You may name your Estate, a charity, a trust or a living person(s) as your beneficiary. You may change your beneficiary(ies) at any time.

Option 1
This option provides a reduced, lifetime monthly benefit to you. No monthly benefit is payable after death. At your death, your named beneficiary(ies) will receive a single payment of any funds remaining in your contributions and interest account. You may name your Estate, a charity, a trust or a living person(s) as your beneficiary. You may change your beneficiary(ies) at any time.

Options 2* & 3
These options provide a reduced monthly benefit for your lifetime and a survivor benefit at your death. If your primary beneficiary predeceases you, there is no change to your benefit and no further benefits will be payable upon your death. If multiple beneficiaries are named, each beneficiary will receive a partial amount based on their respective ages. If one of those beneficiaries predeceases you, there is no change to your benefit and no change to the benefits payable to the surviving beneficiaries upon your death.

Option 2: 100% Joint & Survivor* - At your death, your named, living, primary beneficiary designated at retirement will receive the same monthly allowance.

Option 3: 50% Joint & Survivor - At your death, your named, living, primary beneficiary designated at retirement will receive half of your monthly allowance.

Option 4
Option 4 is highly individualized and you may be able to convert your monthly allowance into one of several methods of payment. If you are interested in Option 4, please visit our self-service website or request an estimate before choosing. The most common choices for Option 4 are:

Flat amount to beneficiary - You designate how much you want your primary beneficiary named at retirement to receive after your death. You may not specify more than the amount payable to you. If your primary beneficiary predeceases you, there is no change to your benefit and no further benefits will be payable upon your death. If you elect multiple beneficiaries and one of those beneficiaries predeceases you, there is no change to your benefit and no change to the benefits payable to the surviving beneficiaries upon your death.

Period Certain - Guaranteed period certain: guarantees a monthly benefit for your lifetime. If you die before the selected number of payments (5, 10, 15, or 20 years), your named beneficiary will receive the value of the remaining payments in a single lump sum.

Retirement Options Form - Page 17 (continued)

Accelerated - An accelerated benefit: you receive 135% of the maximum calculated benefit for the first five continuous years. After this time your benefit will be actuarially reduced for your lifetime. There is no beneficiary benefit.

*Max Amount to Beneficiary** – If Option 2 is unavailable because you have listed a non-spouse beneficiary more than 10 years younger than you, this option provides the highest possible benefit to your beneficiary: This option provides a reduced monthly benefit for your lifetime and the highest survivor benefit at your death to your primary beneficiary(ies) named at retirement. If multiple beneficiaries are named, each beneficiary will receive a partial amount based on their respective ages. If your primary beneficiary predeceases you, there is no change to your benefit and no further benefits will be payable upon your death. If you elect multiple beneficiaries and one of those beneficiaries predeceases you, there is no change to your benefit and no change to the benefits payable to the surviving beneficiaries upon your death.

Other – Please contact our office for an alternative method of payment, if needed.

Options 5A* & 5B
These options provide a reduced monthly allowance for your lifetime. You may only list your spouse or a dependent child as sole primary beneficiary. If your primary beneficiary predeceases you, you will pop-up to the Maximum Plan. Following the death of your spouse primary beneficiary and after one year of remarriage or the birth of a child of that marriage you may re-elect the option with your new spouse as your sole, primary beneficiary. One year after the death of your dependent child primary beneficiary, you may re-elect the option with your spouse as your sole, primary beneficiary, providing you have been married to your spouse for at least a year.

Option 5A: 100% Joint & Survivor Pop-up* - At your death, your named, living, primary beneficiary designated at retirement or upon re-election will receive the same monthly allowance.

Option 5B: 50% Joint & Survivor Pop-up - At your death, your named, living, primary beneficiary designated at retirement or upon re-election will receive one-half of your monthly allowance.

*Please note: To ensure compliance with IRS requirements for qualified plans, retirees might not be eligible to designate the full 100% retirement benefit under Options 2, 5A, or 4 if they elect a non-spouse beneficiary who is more than ten years younger than the member/retiree. If this is applicable, the retiree will be notified of the maximum permissible amount which can be allocated to the non-spouse beneficiary. The maximum permissible amount will be available under Option 4 Max Beneficiary Amount.

NOTE: Under options 2, 3, or 4, if your sole, primary beneficiary is your spouse or a dependent child and they predecease you, you may elect to begin receiving an actuarially reduced benefit with your new spouse or current spouse, respectively, after one year of remarriage. Only Option 5A or 5B allows you to pop-up to the Maximum upon the death of your primary beneficiary.

Regardless of Option Elected
If the Gross benefits paid to you the retiree and your beneficiary(ies) do not exceed your contributions and interest amount at the time of retirement, a refund of the remaining amount will be paid to the primary beneficiary(ies) unless the primary beneficiary predeceases the retiree then the payment will go to the secondary beneficiary(ies).

Escalating Benefit Option Form - Page 18

What is an Escalating Benefit?
You may choose to receive a reduced benefit at retirement, with a guaranteed 2% increase on the anniversary of your retirement every year during your lifetime; however, it can only be elected for the Maximum Plan, Option 2, Option 3, Option 4 Period Certain – 5 years, 10 years, 15 years or 20 years, Option 4 Max Amount to Beneficiary, Option 5A, or Option 5B. If you elect the escalating benefit for an option that provides a monthly benefit to your beneficiary(ies) after your death, this guaranteed increase would continue for the lifetime of your beneficiary(ies) also.

NOTE: An escalating benefit option is further reduced from an option without escalating benefit. An estimate can be requested from ERSGA for the escalating benefit options, or you can visit our website at ers.ga.gov, Logging In to your Account, and Generating a Benefit Estimate for the escalating benefit options.

Who is eligible?

- Service, law enforcement, or involuntary separation retirees may elect an escalating benefit.
- Disability retirees may also elect an escalating benefit.

Escalating Benefit Example:
If an escalating benefit is elected, the retirement benefit will be increased on each anniversary of the retirement date. For example, if an ERS member retires on January 1st and elects an option with an escalating benefit, then in January of the next year the retirement benefit will increase by 2%. And in January of the following year, the retirement benefit will increase by another 2%. These increases will continue each year on the anniversary of the retirement date, for the lifetime of the retiree and, if applicable, the beneficiary(ies) lifetime (for options which provide a monthly benefit to a beneficiary(ies) after retiree's death.)

Naming Your Retirement Allowance Beneficiaries Form – Page 19

- You may name one or more primary and/or secondary beneficiaries. If you want to name more than three, please list the additional beneficiaries on a separate sheet.
- Retirement applications without a listed beneficiary will not be processed.
- Secondary beneficiaries may be changed at any time.
- A will does not take precedence over this designation. Benefits are not assignable by wills. Please verify all birth dates. Correct birth dates are essential in calculating benefits.

Maximum, Option 1, Option 4 Period Certain, Option 4 Accelerated

- You may change beneficiaries at any time. There is no continuing monthly benefit after your death.
- Your secondary beneficiaries will not receive any benefits unless all primary beneficiaries are deceased or have disclaimed their benefits
- If you choose your Estate as the primary beneficiary, you do not need a secondary beneficiary.
- Payment for the month of your death will be made to your estate.

Options 2*, 3, & 4*

- If you name multiple primary beneficiaries, the amount each beneficiary would receive is calculated when you retire based on their ages. Should any beneficiary predecease you, the living beneficiary(ies) would still receive the amount determined at retirement. Your secondary beneficiaries will not receive any benefits unless all primary beneficiaries are deceased. Secondary beneficiaries are not eligible for a monthly benefit.
- You may change your primary beneficiary only if:
    - Your spouse is the sole, primary beneficiary and you get a divorce - this allows a change to the Maximum.
    - After one year of re-marriage or the birth of a child from that remarriage, you may choose the original option naming your new spouse as beneficiary, resulting in a permanent, actuarial reduction to your allowance.
    - Your spouse is the sole, primary beneficiary and predeceases you - after one year of re-marriage or birth of a child from that remarriage, you may re-elect the optional allowance naming the new spouse as beneficiary, resulting in a permanent, actuarial reduction to your allowance.

Options 5A* & 5B

- You may only name your spouse **or** dependent child as sole primary beneficiary. If your primary beneficiary dies before you, your benefit will change to the Maximum.
- If your sole primary beneficiary is your spouse and divorce occurs, you may change to the Maximum by making such election in writing. After one year of re-marriage or the birth of a child you may choose the original option naming the new spouse as beneficiary.
- If your dependent child beneficiary predeceases you, you will change to the Maximum. Beginning one year after the death of the child you may name your current spouse as your sole primary beneficiary under the same option. Benefits will be actuarially reduced.

*To ensure compliance with IRS requirements for qualified plans, retirees might not be eligible to designate the full 100% retirement benefit under Options 2, 5A, or 4 if they elect a non-spouse beneficiary who is more than ten years younger than the member/retiree. If this is applicable, the retiree will be notified of the maximum permissible amount which can be allocated to the non-spouse beneficiary.

Regardless of Option Elected: If the Gross benefits paid to you the retiree and your beneficiary(ies) do not exceed your contributions and interest amount at the time of retirement, a refund of the remaining amount will be paid to the primary beneficiary(ies) unless the primary predeceases the retiree then the payment will go to the secondary beneficiary(ies).

Naming Your Group Term Life Insurance (GTLI) Beneficiaries Form – Page 20

- You may name one or more primary and/or secondary beneficiaries. If you want to name more than three, please list the additional beneficiaries on a separate sheet.
- All Group Term Life Insurance (GTLI) beneficiaries may be changed at any time.
- You may designate percentages to multiple beneficiaries, but the total must equal 100%.
- A will does not take precedence over this designation. Benefits are not assignable by wills.
- Group Term Life Insurance is not assignable.
- This Group Term Life Insurance has no cash value and is payable only upon your death.

Please NOTE: Employees under the GSEPS Plan do not have coverage in the GTLI Program.

O.C.G.A. § 50-36-1(e)(2) Affidavit Form – Page 21

ERS must verify the lawful presence in the United States of any natural person 18 years of age or older who has applied for retirement benefits at the time they apply for benefits.

Residency Affidavit Acceptable Document O.C.G.A § 50-36-1(e)(2)
Effective January 1, 2012, O.C.G.A. § 50-36-1(e) requires that all applicants for a public benefit complete signed and sworn affidavits, and provide at least one secure and verifiable document, as verification of lawful presence within the United States. This page provides additional information regarding acceptable forms of secure and verifiable documents.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status. Only current, UNEXPIRED, documents will be accepted.

- A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An original or certified copy of a birth certificate issued by the United States Department of State, a State, a county, a municipal authority, or a territory of the United States, bearing an official seal, together with copies of legal documents registering any name changes since birth [O.C.G.A. $50-36-2(b)(3); 6 CFR 37.11]
- An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A passport issued by a foreign government together with Form I-94 or other federal form as proof of lawful presence in the United States [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR §41.2]
- A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

Direct Deposit Information – Page 24

1. Enter the name of your financial institution.

2. Check the box indicating whether the account is a Checking Account or a Savings Account.

   Checking: Attach a pre-printed check (with the word VOID printed on it) or authorization letter for the account to which your deposit is to be made to the form on page 24. Starter checks will not be accepted.

   S**avings:** Attach a savings deposit slip or authorization letter to the form page 24.

   For some banks, the routing number is different than what is printed on the deposit slip. Enter your routing number in the space provided.

Authorization Letters

If you are submitting an authorization letter instead of a check or deposit slip, place the letter behind the direct deposit form in your retirement application. The authorization letter must include:

- Type of account
- Name(s) on the account
- Account number
- Routing number

Direct Deposit takes effect with your first monthly payment.

Changing Direct Deposit

After you receive your first payment, changes to Direct Deposit must be received before payroll is processed in order to be effective for the current month. You may change your Direct Deposit online by logging in to your account at ers.ga.gov. Alternatively, you can download a copy of the Direct Deposit form from our website.

Income Tax Withholding Form – Pages 25-28

- Your retirement allowance is subject to federal income taxes and to Georgia income tax if you are a resident of Georgia. Consult a tax advisor if necessary.
- You may change your tax withholdings at any time. However, changes must be received in the ERSGA office by the 18th of the month to ensure the change will be made that month.
- You may change your withholdings online by logging in to your account at ers.ga.gov.
- Alternatively, you can download copies of the federal and state of Georgia tax withholding forms from our website or request a copy from our office.

Georgia State Withholding

- If you do not wish to have Georgia state taxes withheld or you live outside of Georgia, check the box next to line 1.
- If you want to have Georgia state taxes withheld, in the line 2 section check one box indicating your filing status and fill in the number of exemptions.
- You may specify an additional dollar amount to be withheld on line 3. The amount of taxes based on your filing status and exemptions plus the additional amount you list will be deducted from your retirement benefit.

Federal Withholding

- If you **do not** wish to have federal taxes withheld, write “No Withholding” in the space under box 4(c) in Step 4 of the IRS form. You may be required to pay estimated taxes and incur a penalty.
- If you **want** to have federal taxes withheld, follow the instructions on pages 2 and 3 on the IRS form.
- You may specify an additional dollar amount to be withheld. The amount of taxes based on your filing status and exemptions plus the additional amount you list will be deducted from your retirement benefit.

ERSGA
Employees' Retirement System of Georgia
Serving those who serve Georgia

F 1 $ E R S

Disability Retirement Application - ERS

Name _____

Date of Birth _____ (mm/dd/yyyy) Social Security Number _____

Mailing Address _____ (Street/PO Box)

_____ City _____ State _____ Zip

Email Address _____

Home Phone _____ Cell Phone _____

(check one) ☐ Mobile ☐ Land Line

Marital Status (check one)

Unmarried ☐ Married ☐ Spouse's Name _____

Widowed ☐ Divorced ☐

State Employer
(Department/Agency/School System) _____

Position/Title _____

Effective Date of Retirement 1st Day of _____ (Month) _____ (Year)

Type of Retirement (See instructions page 7)

☐ Disability ☐ Injury in Line of Duty

(Disability applicant must complete Parts I through V)

Monthly Retirement Allowance Options

Please choose only one monthly retirement allowance option. If you make a mistake, write your initials next to the correct choice. You may reference pages 8 and 9 of this application, your estimate, the handbook, or Option Chart for additional information regarding the options. Note: The Maximum Plan is the only option available if you are applying for Injury in Line of Duty benefits.

☐ **Maximum Plan**: Benefits cease after my death. **(Only available option for Injury in Line of Duty)**

☐ **Option 1**: At my death, any balance of my contributions and interest will be paid to my beneficiary.

☐ **Option 2:** 100% Joint & Survivor – At my death, my beneficiary will receive the same amount I received as a monthly benefit.

☐ **Option 3:** 50% Joint & Survivor – At my death, my beneficiary will receive half of the amount I received as a monthly benefit.

Option 4: A highly individualized method of payment

☐ **Flat Amount to Beneficiary**: I want my named primary beneficiary to receive $ _____ per month after my death.

☐ **Period Certain** – I want to guarantee my benefit for (check one)

☐ 5 years ☐ 10 years ☐ 15 years ☐ 20 years

☐ **Accelerated** - I want an accelerated benefit of 135% for the first five continuous years and an actuarially reduced benefit thereafter. There is no beneficiary benefit under this option.

☐ **Max Amount to Beneficiary** - I have listed a non-spouse beneficiary more than 10 years younger than me and want the highest possible benefit to my beneficiary, if Option 2 100% Joint & Survivor is unavailable. If Option 2 is available, ERSGA will process my application under Option 2.

☐ **Other** - I want to elect an alternative method of payment. I will contact the ERS office to discuss further.

☐ **Option 5A:** 100% Joint & Survivor Pop-up – At my death, my beneficiary (my spouse or dependent child) will receive the same amount I received as a monthly benefit. If my primary beneficiary predeceases me, my benefit will pop-up to the Maximum Plan.

☐ **Option 5B:** 50% Joint & Survivor Pop-up – At my death, my beneficiary (my spouse or dependent child) will receive half of the amount I received as a monthly benefit. If my primary beneficiary predeceases me, my benefit will pop-up to the Maximum Plan.

NOTE: Option 6 (Partial Lump-sum Option Payment – PLOP) is not available to employees who retire under Disability provisions.

Please Initial _____ Last 4 digits in your SSN _____ Date _____

Escalating Benefit Option

You may elect to take a further reduced benefit in order to receive a guaranteed annual increase of 2% to your gross monthly benefit. You are eligible to elect the Escalating Benefit Option only if you elected one of the following options on page 17:

Maximum Plan
Option 2
Option 3
Option 4 Period Certain – 5 Years
Option 4 Period Certain – 10 Years
Option 4 Period Certain – 15 Years
Option 4 Period Certain – 20 Years
Option 4 Max Amount to Beneficiary
Option 5A
Option 5B

If you elected one of the above options and want to elect the Escalating Benefit, your monthly benefit will be further reduced; however, you will receive a guaranteed 2% increase to your monthly benefit on the anniversary of your retirement each year for your lifetime. If you elected an optional form with monthly payments to your beneficiary after your death, payments to your beneficiary will also increase by 2% each year.

Choose one of the following:

☐ I elected one of the above retirement options on page 17, and choose the Escalating Annuity Benefit with guaranteed 2% annual increase.

☐ I elected one of the above retirement options on page 17, but do ***not*** want the Escalating Annuity Benefit with guaranteed 2% annual increase.

☐ I do ***not*** want the Escalating Annuity Benefit with guaranteed 2% annual increase.

Please Initial _____ Last 4 digits in your SSN _____ Date _____

Primary Beneficiary(ies) for Retirement Benefits

- Maximum, Option 1, Option 4 Period Certain, and Option 4 Accelerated – Any person, estate or organization may be listed.
- Option 2, 3, 4 Flat Amount to Beneficiary, or 4 Max Amount to Beneficiary – Any living person may be listed.
- Option 5A or Option 5B – Only a spouse or a dependent child may be listed, as a sole primary beneficiary.
- If multiple beneficiaries are listed for monthly survivor benefit, benefits will be equally distributed.

As Primary Beneficiary for any retirement benefits due after my death, I designate the following:

Name _____

Mailing Address _____

Date of Birth _____ Relationship _____

Name _____

Mailing Address _____

Date of Birth _____ Relationship _____

Name _____

Mailing Address _____

Date of Birth _____ Relationship _____

Secondary Beneficiary(ies) for Retirement Benefits

Any person, estate or organization may be listed. Required unless Estate or an organization is listed as Primary.

If the Primary Beneficiary that I designated above is deceased at my death, I then designate as Secondary Beneficiary the following:

Name _____

Mailing Address _____

Date of Birth _____ Relationship _____

Name _____

Mailing Address _____

Date of Birth _____ Relationship _____

Name _____

Mailing Address _____

Date of Birth _____ Relationship _____

Please Initial _____ Last 4 digits in your SSN _____ Date _____

Primary Beneficiary(ies) for Group Term Life (GTLI) Benefits

Any person, estate or organization may be listed.

Please NOTE: Employees under the GSEPS Plan do not have coverage in the GTLI Program and should leave this page blank.

As Primary Beneficiary for any GTLI benefits due after my death, I designate the following:

Name _____ Percentage _____ %

Mailing Address _____

Date of Birth _____ Relationship _____

Name _____ Percentage _____ %

Mailing Address _____

Date of Birth _____ Relationship _____

Name _____ Percentage _____ %

Mailing Address _____

Date of Birth _____ Relationship _____

Total Percentage should equal 100%

Secondary Beneficiary(ies) for GTLI Benefits

Any person, estate or organization may be listed. Required unless Estate, or an organization is listed as Primary.

If the Primary Beneficiary that I designated above is deceased at my death, I then designate as Secondary Beneficiary the following:

Name _____ Percentage _____ %

Mailing Address _____

Date of Birth _____ Relationship _____

Name _____ Percentage _____ %

Mailing Address _____

Date of Birth _____ Relationship _____

Name _____ Percentage _____ %

Mailing Address _____

Date of Birth _____ Relationship _____

Total Percentage should equal 100%

Please Initial _____ Last 4 digits in your SSN _____ Date _____

O.C.G.A. § 50-36-1 (e)(2) Affidavit

By executing this affidavit under oath, as an applicant for a monthly retirement benefit, as referenced in O.C.G.A. § 50-36-1, from the Employees' Retirement System of Georgia, the undersigned applicant verifies one of the following with respect to my application for a public benefit:

1) _____ I am a United States citizen.
2) _____ I am a legal permanent resident of the United States.
3) _____ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency.

   My alien number issued by the Department of Homeland Security or other federal immigration agency is: _____

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has attached a copy of at least one secure and verifiable document or photo id as referenced in the Residency Affidavit Acceptable Documents list, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit. The secure and verifiable document provided to ERSGA with this affidavit can best be classified as:

_____.

(Attach a copy of the secure and verifiable document or photo id)

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in _____ (City) _____ (State).

_____
Signature of Applicant

_____
Printed Name of Applicant

Last four digits of SSN _____

_____
Notary Public
My Commission Expires: _____

Subscribed and sworn
before me on this, the
_____ day of _____, 20

NOTE: The notarized Residency Affidavit and a copy of the secure and verifiable document or photo id as referenced in the Residency Affidavit Acceptable Documents list must be returned to ERSGA.

Acknowledgement of Member

My effective retirement date may not be before the first of the month following my final month of employment and no earlier than 30 days after ERS receipt of my complete Disability application. I understand the ERSGA must be notified if I begin actively working or return from leave with or without pay and that my retirement application will be void.

By signing this application I agree to the following conditions:

- I authorize ERSGA to electronically deposit my net monthly allowance into my bank account.
- ERSGA is authorized to adjust any entries made in error.
- This arrangement remains in effect until I cancel or supersede it in writing to ERSGA.
- I agree to immediately notify ERSGA of any change in my checking or savings account information online by Logging In to my online account or downloading a copy of the Direct Deposit form from the website and submitting the completed form.
- No monthly check stubs are issued. Payment history can be viewed by Logging In to my online account at ers.ga.gov.
- Monthly allowances are scheduled for deposit on the last working day of the month.
- Contact ERSGA immediately upon the death of a recipient of this benefit.
- Failure to abide by these conditions can jeopardize my monthly allowance.

Please note: Should you become employed by an ERS employer, you must inform your employer you are an ERS disability retiree. Both you and the ERS employer must notify ERS immediately. Your monthly disability allowance will stop and you will again contribute to ERS as an active member.

I understand that any work performed by a disability retiree is subject to an earnings limitation of the difference between the beginning gross monthly retirement allowance and the earnable compensation used to calculate the disability retirement. The amount of my disability benefit may be limited or reduced if I work or am able to work in a gainful occupation. The disability benefit I receive plus wages cannot be greater than the earnable compensation used to calculate my disability benefit.

ERSGA can request a medical examination of any disability retiree under the age of 60 once a year for the first five years after retirement and once in every three-year period after that to determine earnings capacity.

I have read the retirement application (including instructions) and I understand the retirement options and methods of payment outlined in this application. I have reviewed the checklist on page 29 and completed all applicable items. I further understand that once ERSGA mails or direct deposits my initial benefit check on the last business day of the payroll month, this application cannot be cancelled and the option I chose at retirement can only be changed under very specific, life- changing circumstances as specified in this application.

Applicant's Signature: _____

Last Four Digits of SSN: _____ Date: _____

GSRA Election

The Georgia State Retirees Association (GSRA) is an advocacy organization created by retired state employees for the benefit of state retirees. GSRA promotes the protection and improvement of retirement and health benefits for retirees. You can make GSRA a more effective advocate for you by becoming a member.

Learn more about GSRA on the website: mygsra.com

I give ERSGA permission to share my contact information with GSRA. Yes _____ No _____

Please Initial _____ Last 4 digits in your SSN _____ Date _____

ERSGA
Employees' Retirement System of Georgia
Serving those who serve Georgia

B 2 $ E R S

Direct Deposit Information

Bank Information

Name of Financial Institution _____

☐ Checking ☐ Savings

Savings Routing Number _____

Attach your voided check or savings deposit slip below. **Do not staple.**

For written requests by your financial institution, place letter behind this form in your retirement application.

Attach

Voided Check

or

Savings Deposit Slip

Please Initial _____ Last 4 digits of SSN _____ Date _____

Georgia State Income Tax Withholding

This is a substitute for GA Dept. of Revenue Form G-4P

1. ☐ **I do not want** Georgia state tax withheld from my benefit check. (Do not complete lines 2 or 3)
2. ☐ I want to withhold taxes based on Georgia tax tables using the filing status and the number of exemptions. (You may list an additional dollar amount on line 3.)

   Filing Status: ☐ Single ☐ Head of Household ☐ Married filing separately

   Married Filing Jointly: ☐ One spouse working ☐ Both spouses working

   Exemptions: I claim _____ total dependents/exemptions/allowances.
3. ☐ In addition to the taxes withheld based on the filing status and exemptions selected above, I want $_____ (specific dollar amount) withheld.

Please Initial _____ Last 4 digits in your SSN _____ Date _____

Form **W-4P**

Department of the Treasury
Internal Revenue Service

Withholding Certificate for Periodic Pension or Annuity Payments

Give Form W-4P to the payer of your pension or annuity payments.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See pages 2 and 3 for more information on each step, when to use the estimator at *www.irs.gov/W4App*, and how to elect to have no federal income tax withheld (if permitted).

Step 2: Income From a Job and/or Multiple Pensions/ Annuities (Including a Spouse's Job/ Pension/ Annuity)

Complete this step if you (1) have income from a job or more than one pension/annuity, or (2) are married filing jointly and your spouse receives income from a job or a pension/annuity. **See page 2 for examples on how to complete Step 2.**

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Complete the items below.

(i) If you (and/or your spouse) have one or more jobs, then enter the total taxable annual pay from all jobs, plus any income entered on Form W-4, Step 4(a), for the jobs less the deductions entered on Form W-4, Step 4(b), for the jobs. Otherwise, enter "-0-" . . . $

(ii) If you (and/or your spouse) have any other pensions/annuities that pay less annually than this one, then enter the total annual taxable payments from all lower-paying pensions/ annuities. Otherwise, enter "-0-" . . . . . $

(iii) Add the amounts from items (i) and (ii) and enter the **total** here . . . . . $

TIP: To be accurate, submit a new Form W-4P for all other pensions/annuities if you haven't updated your withholding since 2021 or this is a new pension/annuity that pays less than the other(s). Submit a new Form W-4 for your job(s) if you have not updated your withholding since 2019.

Complete Steps 3–4(b) on this form only if (b)(i) is blank **and** this pension/annuity pays the most annually. Otherwise, do not complete Steps 3–4(b) on this form.

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $

Multiply the number of other dependents by $500 . . . . . $

Add other credits, such as foreign tax credit and education tax credits $

Add the amounts for qualifying children, other dependents, and other credits and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs or pension/annuity payments). If you want tax withheld on other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, taxable social security, and dividends . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the basic standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld from **each payment** . **4(c)** $

Step 5: Sign Here

Your signature (This form is not valid unless you sign it.) **Date**

General Instructions

Section references are to the Internal Revenue Code.

Future developments. For the latest information about any future developments related to Form W-4P, such as legislation enacted after it was published, go to *www.irs.gov/FormW4P*.

Purpose of form. Complete Form W-4P to have payers withhold the correct amount of federal income tax from your periodic pension, annuity (including commercial annuities), profit-sharing and stock bonus plan, or IRA payments. Federal income tax withholding applies to the taxable part of these payments. Periodic payments are made in installments at regular intervals (for example, annually, quarterly, or monthly) over a period of more than 1 year. Don't use Form W-4P for a nonperiodic payment (note that distributions from an IRA that are payable on demand are treated as nonperiodic payments) or an eligible rollover distribution (including a lump-sum pension payment). Instead, use Form W-4R, Withholding Certificate for Nonperiodic Payments and Eligible Rollover Distributions, for these payments/distributions. For more information on withholding, see Pub. 505, Tax Withholding and Estimated Tax.

Choosing not to have income tax withheld. You can choose not to have federal income tax withheld from your payments by writing "No Withholding" on Form W-4P in the space below Step 4(c). Then, complete Steps 1a, 1b, and 5. Generally, if you are a U.S. citizen or a resident alien, you are not permitted to elect not to have federal income tax withheld on payments to be delivered outside the United States and its territories.

Caution: If you have too little tax withheld, you will generally owe tax when you file your tax return and may owe a penalty unless you make timely payments of estimated tax. If too much tax is withheld, you will generally be due a refund when you file your tax return. If your tax situation changes, or you chose not to have federal income tax withheld and you now want withholding, you should submit a new Form W-4P.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Have social security, dividend, capital gain, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

2. Receive these payments or pension and annuity payments for only part of the year.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you (or you and your spouse) receive. If you do not have a job and want to pay these taxes through withholding from your payments, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

Payments to nonresident aliens and foreign estates. Do not use Form W-4P. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities, and Pub. 519, U.S. Tax Guide for Aliens, for more information.

Tax relief for victims of terrorist attacks. If your disability payments for injuries incurred as a direct result of a terrorist attack are not taxable, write "No Withholding" in the space below Step 4(c). See Pub. 3920, Tax Relief for Victims of Terrorist Attacks, for more details.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you have at least one of the following: income from a job, income from more than one pension/annuity, and/or a spouse (if married filing jointly) that receives income from a job/pension/annuity. The following examples will assist you in completing Step 2(b).

Example 1. Bob, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Bob also has a job that pays $25,000 a year. Bob has no other pensions or annuities. Bob will enter $25,000 in Step 2(b)(i) and in Step 2(b)(iii).

If Bob also has $1,000 of interest income, which he entered on Form W-4, Step 4(a), then he will instead enter $26,000 in Step 2(b)(i) and in Step 2(b)(iii). He will make no entries in Step 4(a) on this Form W-4P.

Example 2. Carol, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Carol does not have a job, but she also receives another pension for $25,000 a year (which pays less annually than the $50,000 pension). Carol will enter $25,000 in Step 2(b)(ii) and in Step 2(b)(iii).

If Carol also has $1,000 of interest income, then she will enter $1,000 in Step 4(a) of this Form W-4P.

Example 3. Don, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Don does not have a job, but he receives another pension for $75,000 a year (which pays more annually than the $50,000 pension). Don will not enter any amounts in Step 2.

If Don also has $1,000 of interest income, he won't enter that amount on this Form W-4P because he entered the $1,000 on the Form W-4P for the higher paying $75,000 pension.

Example 4. Ann, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Ann also has a job that pays $25,000 a year and another pension that pays $20,000 a year. Ann will enter $25,000 in Step 2(b)(i), $20,000 in Step 2(b)(ii), and $45,000 in Step 2(b)(iii).

If Ann also has $1,000 of interest income, which she entered on Form W-4, Step 4(a), she will instead enter $26,000 in Step 2(b)(i), leave Step 2(b)(ii) unchanged, and enter $46,000 in Step 2(b)(iii). She will make no entries in Step 4(a) of this Form W-4P.

If you are married filing jointly, the entries described above do not change if your spouse is the one who has the job or the other pension/annuity instead of you.

Multiple sources of pensions/annuities or jobs. *If you (or if married filing jointly, you and/or your spouse) have a job(s), do NOT complete Steps 3 through 4(b) on Form W-4P. Instead, complete Steps 3 through 4(b) on the Form W-4 for the job. If you (or if married filing jointly, you and your spouse) do not have a job, complete Steps 3 through 4(b) on Form W-4P for* ***only*** *the pension/annuity that pays the most annually. Leave those steps blank for the other pensions/annuities.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. Including these credits will increase your payments and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include amounts from any job(s) or pension/annuity payments. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than

Specific Instructions *(continued)*

having tax on other income withheld from your pension, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 6, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions.

This includes itemized deductions, the additional standard deduction for those 65 and over, and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from **each payment**. Entering an amount here will reduce your payments and will either increase your refund or reduce any amount of tax that you owe.

Note: If you don't give Form W-4P to your payer, you don't provide an SSN, or the IRS notifies the payer that you gave an incorrect SSN, then the payer will withhold tax from your payments as if your filing status is single with no adjustments in Steps 2 through 4. For payments that began before 2024, your current withholding election (or your default rate) remains in effect unless you submit a new Form W-4P.

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1	Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income	**1**	$
2	Enter: • $29,200 if you're married filing jointly or a qualifying surviving spouse • $21,900 if you're head of household • $14,600 if you're single or married filing separately	**2**	$
3	If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-"	**3**	$
4	If line 3 equals zero, and you (or your spouse) are 65 or older, enter: • $1,950 if you're single or head of household. • $1,550 if you're married filing separately. • $1,550 if you're a qualifying surviving spouse or you're married filing jointly and one of you is under age 65. • $3,100 if you're married filing jointly and both of you are age 65 or older. Otherwise, enter "-0-". See Pub. 505 for more information	**4**	$
5	Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information	**5**	$
6	**Add** lines 3 through 5. Enter the result here and in **Step 4(b)** on Form W-4P	**6**	$

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. You are required to provide this information only if you want to (a) request federal income tax withholding from pension or annuity payments based on your filing status and adjustments; (b) request additional federal income tax withholding from your pension or annuity payments; (c) choose not to have federal income tax withheld, when permitted; or (d) change a previous Form W-4P. To do any of the aforementioned, you are required by sections 3405(e) and 6109 and their regulations to provide the information requested on this form. Failure to provide this information may result in inaccurate withholding on your payment(s). Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Disability Retirement Application PART I
Checklist

_____ I have initialed, written the last four numbers of my Social Security number, and dated pages 17, 18, 19, 20, 23 and 24.

_____I have elected a monthly retirement allowance option on page 17.

_____I have made my Escalating Option election on page 18.

_____I have designated my beneficiaries for retirement benefits on page 19 and GTLI benefits on page 20.

_____I have completed page 21 with notarization and included at least one secure and verifiable document.

_____I have signed, written the last four numbers of my Social Security number and dated page 22

_____I have made my GSRA election on page 23.

_____I have completed my direct deposit information on page 24 and included a voided check.

_____I have completed my Georgia State and federal withholding elections on pages 25 and 26.

Parts II – V must also be completed.

Employees' Retirement System of Georgia
Two Northside 75 Suite 300
Atlanta, GA 30318-7701
Local (404) 350-6300
Toll Free 1-800-805-4609
ers.ga.gov

ERSGA
Employees' Retirement System of Georgia
Serving those who serve Georgia

Two Northside 75, Suite 300
Atlanta, GA 30318-7778
Local (404) 350-6300
Toll Free 1-800-805-4609
www.ers.ga.gov

DISABILITY RETIREMENT APPLICATION PART II

EMPLOYEE'S DISABILITY SELF-REPORT (ERS, PSERS, & GJRS ONLY)

PART II - Instructions

Sections 1 & 2 – Employee General Information / Disability Information

Type or print. Blue ink is preferred.
Complete all appropriate information.
It is the applicant's responsibility to submit the complete application packet (Parts I – V) to ERSGA.
Attach additional sheet(s) if necessary. Identify the questions being answered, then sign and date any attached sheet(s).
Remember to fill in your Social Security Number on the top right corner of every page.

Section 3 – Employee Request for Information

Please list ONLY physicians (including specialists), hospitals and/or clinics from which you are requesting medical information relating to your disability. Include names, complete addresses, zip codes and phone numbers. If you need additional space, please attach a separate sheet(s).

NOTE: Your disability application WILL NOT BE ACCEPTED until we have received the disability reports from ALL of the providers you have listed.

Section 4 – Employee Signature

Please sign and date in the space provided to confirm that you understand the instructions related to this Employee's Disability Self-Report, that all the information you have provided is correct, and that you understand and agree that it is your responsibility to ensure delivery of the medical information outlined in Section 3.

Return the completed Retirement Application (Parts I – V) to:

Employees' Retirement System of Georgia
Two Northside 75, Suite 300
Atlanta, Georgia 30318-7778

B 3 $ E R S

SS# _____/_____/_____

Disability Retirement Application Part II

EMPLOYEE'S DISABILITY SELF-REPORT

SECTION 1 – EMPLOYEE GENERAL INFORMATION

Name of Current Employer, Agency, or School System: _____

Current Position: _____

Name: _____
(Last, Suffix, First, Middle Initial)

Mailing Address: _____
Number, Street, and Apartment # City State Zip Code

Daytime Phone: (____) _____ Evening Phone: (____) _____ Cell Phone: (____) _____

Have you applied for Social Security disability benefits? YES _____ NO _____

If Yes, you must provide us with a copy of your award notice or the last status of your claim.

Are you currently employed by the above listed Employer, Agency, or School System? YES __ NO _____

If No, what was your date of termination (MM/DD/YYYY): _____

If Yes, are you on leave? YES _____ NO _____

If Yes, the type of leave is: _____

Date Leave Began: _____ (MM/DD/YYYY) Date Leave Ends: _____ (MM/DD/YYYY)

Your immediate Supervisor's name: _____

Supervisor's Title: _____

Supervisor's Phone Number: (_____) _____

Supervisor's Fax Number: (_____) _____

SS# _____/_____/_____

SECTION 2 – EMPLOYEE DISABILITY INFORMATION

Please state the specific duties in the job position listed above that you have not been able to perform, or are not now able to perform.

What specific physical or mental conditions/diagnoses/ diseases prevent you from performing these duties?

Explain what you feel or experience.

When did these first become known to you?

When did these first interfere with your job performance?

List any other health problems you have.

List all prescriptive and non-prescriptive medicines (including dosages) that you currently take.

SS# _____/_____/_____

SECTION 2 – EMPLOYEE DISABILITY INFORMATION – continued

Activities of Daily Living:

Are you currently having problems completing your daily routine? (Please circle all that apply).

Personal care	Meals	Shopping
Household duties	Social contacts	Leisure activities

Please describe how these daily activities are affected by your disabling condition and how you compensate. If more space is needed, please feel free to add additional pages:

SS# _____/_____/_____

SECTION 2 – EMPLOYEE DISABILITY INFORMATION – continued

Activities of Daily Living, continued:

How do you get around? (circle) drive car are driven bus taxi

Other _____

How far can you walk? _____

For how many minutes can you walk? _____

Why do you have to stop? _____

How many stairs steps can you climb without resting? _____

Is there anything else we need to know? _____

_____

_____

Activities of Employment:

Are you gainfully employed (working for pay) anywhere other than the position associated with this disability application? Yes _____ No _____

If so, where are you employed? (name of business and address): _____

_____

What is your position? _____

How many hours per week do you normally work? _____

Have you had to stop working because of your condition? Yes __ No _____

If yes, why? (please be specific) _____

Have you tried to work after you became ill or injured? Yes ___ No _____

If yes, please explain what happened _____

_____

SS# _____/_____/_____

SECTION 3 – EMPLOYEE REQUEST FOR INFORMATION

Please list ONLY physicians (including specialists), hospitals and/or clinics from whom you are supplying medical information relating to your disability. Medical information older than 18 months may not be considered. Include names, complete addresses, zip codes, and phone numbers. If you need additional space, please attach a separate sheet(s).

NOTE: Your disability application WILL NOT BE ACCEPTED until we have received the disability related reports from ALL of the providers you have listed.

Name:
Address:

Phone Number: ( ) Fax Number: ( )

Name:
Address:

Phone Number: ( ) Fax Number: ( )

Name:
Address:

Phone Number: ( ) Fax Number: ( )

Name:
Address:

Phone Number: ( ) Fax Number: ( )

Name:
Address:

Phone Number: ( ) Fax Number: ( )

Name:
Address:

Phone Number: ( ) Fax Number: ( )

SECTION 4 – EMPLOYEE SIGNATURE

By signing this disability self-report I affirm that all of the information provided is correct and that I have read and understood the instructions on this report. If any of the information provided is found to be false or incorrect, my disability retirement could be denied or my disability retirement could be invalidated.

I understand that I am not allowed to return to my work duties while this application is in process, and that if I should return to duty, this application is voided.

I further understand and agree that it is my responsibility to ensure delivery of the medical information outlined above.

Signature: _____ Date: _____
(MM/DD/YYYY)

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DISABILITY RETIREMENT APPLICATION
PART III

EMPLOYER'S DISABILITY REPORT
(ERS, PSERS, & GJRS ONLY)

PART III - Instructions

Section 1 – Employee Information

To be completed by the employee.

Type or print. Blue ink is preferred.

Write your Social Security number in the top right corner of every page.

Section 2 – Human Resources Director Information

To be completed by the employee's Human Resources Director.

Type or print. Blue ink is preferred.

Attach additional sheet(s) of paper if necessary. Also, identify the question(s) being answered, sign and date the attached sheets.

You must also complete Part V of the Disability application, and attach a copy of the employee's job description and detailed job responsibilities as well as a copy of the employee's last performance evaluation. The employee must provide a copy of the job description to each physician and medical provider.

Section 3 - Immediate Supervisor's Information

To be completed by the employee's Immediate Supervisor.

Type or print. Blue ink is preferred.

Attach additional sheet(s) of paper if necessary. Also, identify the question(s) being answered, sign and date the attached sheets.

Return this completed form to the applicant at the address on page 2.

Effective July 1, 2006, the Alternative Position Form must be completed as part of the Disability Retirement Application process. Check our website for a downloadable copy and additional information.

B 4 $ E R S

SS# _____/_____/_____

Disability Retirement Application Part III

EMPLOYER'S DISABILITY REPORT (ERS, PSERS, & GJRS ONLY)

SECTION 1 – EMPLOYEE INFORMATION

Name: _____
(Last, Suffix, First, and Middle Initial)

Employee ID #: _____ Requested Retirement Date: _____
(MM/DD/YYYY)

Employee's Mailing Address: _____
Number, Street, and Apartment # City State Zip Code

SECTION 2- HUMAN RESOURCES DIRECTOR INFORMATION

Employee's Current Employer, Agency, or School System: _____

Employer Mailing Address: _____
Number, Street, and Apartment # City State Zip Code

Employee's Current Position Title and effective date: _____

NOTE: Attach a copy of complete job description which details job responsibilities, including critical job duties and a copy of the last performance evaluation in Part V of this Application.

Does this Employer, Agency, or School System currently employ this employee? YES ____ NO _____

If No, what was the date of termination (MM/DD/YYYY): _____

If Yes, is the Employee on leave? YES ____NO _____ If Yes, the type of leave is : _____

Date Leave Began (MM/DD/YYYY): _____Date Leave Ends(MM/DD/YYYY): _____

Has this employee been absent from work due to the claimed disabling condition? YES ___ NO _____

If Yes, please provide beginning and ending dates of absence:

Has this employee applied for Workers' Compensation benefits based on this disabling condition? YES _NO _____

Does the employee's position require a special license or certification? YES _____ NO _____

If Yes, has the employee been evaluated by the certifying agency? YES _____ NO _____

SS# _____/_____/_____

SECTION 2- HUMAN RESOURCES DIRECTOR INFORMATION – cont.

Has the license or certification been suspended or revoked? _____YES _____NO

If Yes, please give the date of suspension or revocation (MM/DD/YYYY): _____
Please attach the supporting documentation.

Does the employer require that individuals meet any medical guidelines or standards in order to be hired into the position currently held by the employee? _____YES _NO

If Yes, provide these guidelines or standards:

If Yes, did the employee meet these guidelines or standards at the time he or she was hired? _____YES _NO

If Yes, please provide the original medical assessment (if available) and any subsequent medical assessments for the current position.

Is there anything that you feel will help the Medical Board make a decision on the disability status of this employee?

I certify that this employee has been placed on leave and that ERSGA will be notified if the employee returns to duty.

Human Resources Director's Name _____

Human Resources Director's Signature _____

Title _____ Date _____

Phone Number (_____) _____ FAX Number (_____) _____

Email Address: _____

SECTION 3- IMMEDIATE SUPERVISOR'S INFORMATION

If this employee is on leave or terminated, have you seen this employee since the last day worked? __YES __NO

If Yes, give the date of observation: _____
(MM/DD/YYYY)

In addition, please describe the employee's condition when you last saw the employee.

How long have you observed this employee's work performance in the current position (give dates – MM/DD/YYYY):

SS# _____/_____/_____

SECTION 3- IMMEDIATE SUPERVISOR'S INFORMATION – cont.

Please state the specific duties in the job description, referred to above, that the employee, in your opinion, is not now able to perform. Please identify those that are critical to the position.

Based on your observations, what, in your opinion, prevents the employee from performing these duties?

Has the employer provided any accommodations to allow the employee to perform these duties? If so, what were these accommodations and for how long?

Based on your observations and in your opinion, is this person disabled from performing the duties of the current position held? Please summarize your reasons.

Immediate Supervisor's Name _____

Immediate Supervisor's Signature _____

Title _____ Date _____

Phone Number (____) _____ FAX Number (_____) _____

Email Address: _____

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DISABILITY RETIREMENT APPLICATION PART IV

EMPLOYEE'S REQUEST FOR DISABILITY INFORMATION FROM PHYSICIAN/PHYSICIAN'S REPORT (ERS, PSERS, & GJRS ONLY)

PART IV - Instructions

Section 1 – Employee General Information

Type or print. Blue ink preferred.
Attach a copy of your job description.
Write your Social Security Number in the top right corner of every page.

It is your responsibility to submit the complete application packet (Parts I – V) to ERSGA.

Section 2 – Physician Information

This section is to be completed by the employee.
Please provide the requested information about your physician.

Section 3 – Employee Authorization for Release of Medical Information

This section is to be completed by the employee
Please sign and date this authorization.

REMEMBER: You are responsible for any charges relating to this authorization.

Section 4 – Employee Disability Information

To be completed by Physician

This patient has applied for disability retirement. Your information is vital in determining the disability status for the job currently held. A job description is attached.

The patient's signed authorization for release of any and all medical records will be found on page 2 of this form. Confidentiality will be maintained.

Be sure to include all records that document and support the medical diagnosis, such as history, copies of tests, office notes, imaging reports, hospital admissions, operative notes, discharge summaries and referral reports.

Please bill the patient for any charges relating to this request.

If you need more space to answer these questions, please attach additional pages.

E 9 $ E R S

SS# _____/_____/_____

Disability Retirement Application Part IV

EMPLOYEE'S REQUEST FOR DISABILITY INFORMATION FROM PHYSICIAN/PHYSICIAN'S REPORT (ERS, PSERS, & GJRS ONLY)

SECTION 1 – EMPLOYEE GENERAL INFORMATION
To be completed by employee

Name: _____
(Suffix, Last, First, and Middle Initial)

Mailing Address: _____
Number, Street, and Apartment # City State Zip Code

Position Title: _____

NOTE: Attach a copy of your complete employer job description which details job responsibilities, including critical job duties.

SECTION 2 – PHYSICIAN INFORMATION
To be completed by employee

Physician's Name (Last, First and Middle Initial, if applicable) and Specialty:

_____

Mailing Address: _____
Number, Street, and Apartment # City State Zip Code

Daytime Phone: ( ) Fax Number: ( )

E-mail Address (if applicable): _____

SECTION 3 – EMPLOYEE AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This is my written authorization to release to the Employees' Retirement System of Georgia (ERSGA) any and all medical records and information for the purpose of processing my disability retirement application. This includes any psychiatric/psychological records.

Signature: _____ Date: _____
(MM/DD/YYYY)

SS# _____/_____/_____

SECTION 4 – EMPLOYEE DISABILITY INFORMATION

To be completed by Physician

You have been named as a treating physician by this patient. A job description is attached. Please provide a current evaluation of whether this patient is medically or physically incapable of further performance of these duties, and whether such incapacity is likely to be permanent.

If more space is needed, please attach additional pages.

Important – Please attach all records that document and support the medical diagnosis, such as history, copies of tests, office notes, typed imaging reports, hospital admissions, operative notes, discharge summaries, and referral reports for the past 18 months.

What is/are the diagnosis/diagnoses for the cause of the disability?

When was the onset of the disability?

What are the specific physical findings and test results confirming this diagnosis?

What are the specific conditions disabling this patient?

What treatment have you recommended? Has the patient followed through with the recommended treatment? Please give dates (MM/DD/YYYY) and the results of treatment.

Are any treatments, tests, or surgery pending or anticipated? Please list.

SS# _____/_____/_____

SECTION 4 – EMPLOYEE DISABILITY INFORMATION – cont.

To be completed by Physician

Have you referred this patient to any other physician(s)? If so, please give the name, specialty, address and date of referral.

Please give any other information that you think will assist in the determination of this person's case. If more space is needed, please attach additional pages.

For the currently held position and according to the attached employer job description, I find that this patient is (please check one - REQUIRED):

_____Able to perform the job as described.

_____Unable to perform the job as described at this time, but may be able to recover sufficiently to return to work by _____.
(MM/DD/YYYY)

_____Unable to perform the job as described and I am recommending disability retirement. Please enter the specific job duties that the patient cannot perform:

IMPORTANT: Please attach all records that document and support the medical diagnosis, such as history, copies of tests, office notes, typed imaging reports, hospital admissions, operative notes, discharge summaries, and referral reports for the past 18 months.

SECTION 5 – PHYSICIAN / HOSPITAL / CLINIC CERTIFICATION

I certify that the above information is true.

Physician/Hospital/Clinic's Authorized Signature: _____

Title: _____ Date: _____
(MM/DD/YYYY)

Phone Number: (_____) _____ Fax Number: (_____) _____

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DISABILITY RETIREMENT APPLICATION
PART V

JOB DESCRIPTION
(ERS, PSERS, & GJRS ONLY)

F 0 $ E R S

SS# _____/_____/_____

Disability Retirement Application
Part V

JOB DESCRIPTION (ERS, PSERS, & GJRS ONLY)

HUMAN RESOURCES DIRECTOR

Type or print. Blue ink preferred.
Attach a copy of the job description.
Write the member's Social Security Number in the top right corner of this page.

Member's Name: _____
(Last, Suffix, First, and Middle Initial)

Mailing Address: _____
Number, Street, and Apartment # City State Zip Code

Essential Functions: List the essential functions of this employee's job.

Attach a copy of this employee's job description and detailed job responsibilities.

Human Resources Director's Name _____

Human Resources Director's Signature _____

Title _____ Date _____

Phone Number (____) _____ FAX Number (_____) _____

Email Address: _____