MONTHLY RETIREMENT ALLOWANCE OPTIONS

Please choose only one monthly retirement allowance option. If you make a mistake, write your initial next to the correct choice. You may reference page 6 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 named, living 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.

☐ SPECIALIZED SPECIFIED – I am an **Old Plan** member with **34** years of service and if eligible, I want to receive 90% of my high salary with the remainder converted to a monthly benefit to my named living beneficiary designated at retirement as listed on my estimate. I understand that if my benefit does not exceed 90% my application will be processed under the Maximum Plan.

☐ 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 four digits in your SSN _____ Date _____

Naming Your Retirement Allowance Beneficiaries

- You may name one or more primary and/or contingent 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 and Option1

- You may change beneficiaries at any time.
- Your secondary beneficiaries will not receive any benefits unless all primary beneficiaries are deceased or have disclaimed their benefit.
- If you choose your Estate as the primary beneficiary, you do not need a secondary beneficiary.
- If you name more than one primary beneficiary, any benefits due at your death will be distributed equally to each of your surviving primary beneficiaries.
- If you name multiple beneficiaries, you may designate the percentage you want each beneficiary to receive. Just put the percentage in parentheses (__%) after each beneficiary's name **(must equal 100%).**

Options 2*, 3, & 4*

- If you name multiple primary beneficiaries, the amount each beneficiary would receive is calculated when you retire. Should any beneficiary predecease you, the living beneficiary(ies) would still receive the amount determined at retirement.
- 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 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).

Primary Beneficiary(ies) for Retirement Benefits

Maximum, Option 1, Option 4 Period Certain & Accelerated – Any person, estate or organization may be listed. Option 2, 3, 4 Specialized Specified, 4 Specified, or 4 Max Beneficiary Amount – Any living person may be listed. Option 5A or Option 5B– Only a spouse or a dependent child may be listed.

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_____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 100 %

Secondary Beneficiary(ies) for Retirement Benefits

Any person, estate or organization may be listed.
Required unless Estate, an organization, or multiple beneficiaries 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 100 %

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

Naming Your Group Term Life Insurance (GTLI) Beneficiaries

• 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%.**

• If you do not specify percentages, your beneficiaries will receive equal amounts.

• A will does not take precedence over this designation.

• 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: The following members do not have coverage in the GTLI Program:

- Employees under the GSEPS Plan
- Members that terminate employment and vest his/her retirement, to retire at a later date, with less than 18 years of creditable service (excluding forfeited leave)
- Members that terminate employment and vest his/her retirement with at least 18 years of creditable service (excluding forfeited leave), and a written request to discontinue GTLI coverage was received by ERSGA.

Primary Beneficiary(ies) for GTLI Benefits

Any person, estate or organization may be listed.

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 100 %

Secondary Beneficiary(ies) for GTLI Benefits

Any person, estate or organization may be listed.
Required unless Estate, an organization, or multiple beneficiaries 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 100 %

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

Income Tax Withholding Instructions

- 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 Accessing your Account at www.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.

Federal Withholding

- If you **do not** wish to have federal taxes withheld, check the box next to line 1. You may be required to pay estimated taxes and incur a penalty.
- If you **want** to have federal 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.

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.

Direct Deposit Instructions

- Check the box indicating whether the account is a Checking Account or a Savings Account.
- To deposit your benefit into a *checking* account, a pre-printed check (with the word VOID printed on it) from the account to which your deposit is to be made must be attached to this application. Starter checks will not be accepted.
- To deposit your benefit into a savings account, the financial institution, the account number, and 9- digit routing number must be written in the spaces provided on page 15.
- Direct deposit takes effect with your first monthly payment.

NOTE: 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 accessing your account at www.ers.ga.gov. Alternatively, you can download a copy of the Direct Deposit form from our website or request a copy from our office.

Income Tax Withholding

Federal Withholding: This is a substitute for IRS Form W-4P

If no election is made, ERSGA will default to withhold based on Single claiming 0.

☐ I **do not** want federal tax withheld from my benefit check. (Do not complete lines 2 or 3)

☐ I want to withhold taxes based on IRS tax tables using the filing status and the number of exemptions. (You may list an additional dollar amount on line 3.)

Filing Status: ☐ Single ☐ Married ☐ Married but withhold at the higher Single Rate

Exemptions: I claim _____ total dependents/exemptions/allowances.

☐ In addition to the taxes withheld based on the filing status and exemptions selected above, I want $ _____(specific dollar amount) withheld.

Georgia State Withholding: This is a substitute for Form G-4P

If no election is made, ERSGA will default to withhold based on Single claiming 0.

☐ I **do not** want Georgia state tax withheld from my benefit check. (Do not complete lines 2 or 3)

☐ I want to withhold taxes based on tax tables using the filing status and the number of exemptions. (You may list an additional dollar amount on line 3.)

Filing Status (Choose one): ☐ Single ☐ Head of Household ☐ Married Filing Separate

Married filing jointly: ☐ One Spouse Working ☐ Both Spouses Working

Exemptions: I claim _____ total dependents/exemptions/allowances.

☐ In addition to the taxes withheld based on the filing status and exemptions select above, I want $ _____(specific dollar amount) withheld.

Direct Deposit Information

Please check the appropriate box and follow the directions on page 14 of this application.

☐ CHECKING ***A voided pre-printed check must be attached. Starter checks will <u>not</u> be accepted.***

☐ SAVINGS Please provide the following information:

Financial Institution _____

Account number _____

9-digit routing or transit number _____

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

O.C.G.A. § 50-36-1(e)(2) Affidavit

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 Documents 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. The following page contains the affidavit that must be signed and notarized; 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.

- 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 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 [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]
- In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]

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 _____

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE
___ DAY OF _____, 20____

_____
NOTARY PUBLIC
My Commission Expires:

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.

THE RETIREMENT PROCESS

ERS 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 ERS has received it.

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 requirement 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 ERS Medical Board evaluate Disability Retirement applications to determine whther 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.

Disability Retirement Application PART I Checklist

___ I have initialed, written the last four numbers of my Social Security number, and dated pages 7, 9, 11, 13, & 15.

___ I have elected a monthly retirement allowance option on page 7.

___ I have designated my beneficiaries for retirement benefits on page 9 and GTLI benefits on page 11.

___ I have completed my election of Federal and Georgia State withholdings on page 13.

___ I have completed my direct deposit information on page 13 **and** included a voided check.

___ I have completed page 15 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 17.

Parts II – V must also be completed.

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 form leave with or without pay . I also understand 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 through my Account Access 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 Accessing your Account on our website www.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 are 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 further understand that once ERSGA mails 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: _____

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

SECTION 1 – EMPLOYEE GENERAL INFORMATION INSTRUCTIONS

Type or print using black ink.
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.

SS# _____/_____/_____

Disability Retirement Application
Part II

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

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: (____) _____

SECTION 2 – EMPLOYEE DISABILITY INFORMATION INSTRUCTIONS

Type or print using black ink.
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.

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.

SECTION 2 – EMPLOYEE DISABILITY INFORMATION INSTRUCTIONS

Type or print using black ink.
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.

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:

SECTION 2 – EMPLOYEE DISABILITY INFORMATION INSTRUCTIONS

Type or print using black ink.
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.

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 _____

SECTION 3 – EMPLOYEE REQUEST FOR INFORMATION INSTRUCTIONS

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 INSTRUCTIONS

Please sign and date in the space provided to confirm that you understand the instruc- tions 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 responsibil- ity 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

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)

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

DISABILITY RETIREMENT APPLICATION
PART III

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

SECTION 1 – EMPLOYEE INFORMATION INSTRUCTIONS

To be completed by the employee.

Type or print using black ink.

Remember to write your Social Security number in the top right corner of every page.

SECTION 2 – EMPLOYER INFORMATION INSTRUCTIONS (ERS, PSERS & GJRS ONLY)

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

Type or print using black ink.

Complete all appropriate information.

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

Complete Part V 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. This applicant must provide a copy of the job description to each physician and medical provider.

Return this completed form to the applicant at the address on page 3.

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.

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.

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 _____

SECTION 2 – EMPLOYER INFORMATION INSTRUCTIONS – cont. (ERS, PSERS & GJRS ONLY)

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

Type or print using black ink.

Complete all appropriate information.

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

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.

Return this completed form to the applicant at the address on page 3.

SECTION 3 - IMMEDIATE SUPERVISOR'S INFORMATION INSTRUCTIONS (ERS, PSERS & GJRS only)

To be completed by the employee's Immediate Supervisor.

Type or print using black ink.

Complete all appropriate information.

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

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.

Return this completed form to the applicant at the address on page 3.

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 cur- rent 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 ERS will be notified if the employee returns to duty.

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):

SECTION 3- IMMEDIATE SUPERVISOR'S INFORMATION INSTRUCTIONS (ERS, PSERS & GJRS only)

To be completed by the employee's Immediate

Supervisor. Type or print using black ink.

Complete all appropriate information.

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

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.

Return this completed form to the applicant at the address on page 3.

SECTION 4- DEPARTMENTAL/AGENCY HEAD CERTIFICATION INSTRUCTIONS (ERS, PSERS & GJRS only)

To be completed by the Departmental/Agency

Head. Type or print using black ink.

Complete all appropriate information.

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

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.

Return this completed form to the applicant at the address on page 3.

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 posi- tion held? Please summarize your reasons.

Immediate Supervisor's Signature _____

Title _____ Date _____

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

Email Address: _____

SECTION 4- Departmental/Agency Head Certification

The Following employee of your Department/Agency is making application for Disability Retirement Benefits to the Employees' Retirement System, under Georgia Statute O.C.G.A. §47-2-123 [or O.C.G.A. §47-2-221]

Employee's Name: _____
PLEASE PRINT – First, Middle Initial, and Last Name

The Employees' Retirement System of Georgia's Board of Trustees requires your acknowledgment, as indicated by your signature below, of this employee applying for Disability Retirement.

_____ _____
Department/Agency Head's Name – PRINT Department/Agency Head's Signature

_____
Date

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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 INSTRUCTIONS

Type or print using black ink.
Complete all appropriate information.
Attach a copy of your job description.
Remember to 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 INSTRUCTIONS

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

Please sign and date this authorization.

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

E 9 $

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)

SECTION 4 – EMPLOYEE DISABILITY INFORMATION INSTRUCTIONS

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.

You have been named as a treating physician by this patient. We need a current evaluation. Please state specifically whether or not you determined that this patient is disabled for the current job held. The patient's signed authorization for release of any and all medical records will be found on page one of this form. Confidentiality will be maintained.

Document diseases, diagnoses, current condition, and prognosis and include copies of tests, office notes, blood tests and imaging reports for the past 18 months. Be sure to include any records that document and support the medical diagnosis, such as history, 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.

SS# _____/_____/_____

SECTION 4 – EMPLOYEE DISABILITY INFORMATION

To be completed by Physician

IMPORTANT: Please read all instructions on page 4 carefully before answering the questions below.

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? Please attach copies of these test re- sults. If cancer is involved, attach copies of the confirming pathology reports. If AIDS is involved, attach copies of HIV and CD4 test reports. If you do not have copies of these reports, please tell us where they can be obtained.

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.

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

SECTION 4 – EMPLOYEE DISABILITY INFORMATION INSTRUCTIONS

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.

You have been named as a treating physician by this patient. We need a current evaluation. Please state specifically whether or not you determined that this patient is disabled for the current job held. The patient's signed authorization for release of any and all medical records will be found on page one of this form. Confidentiality will be maintained.

Document diseases, diagnoses, current condition, and prognosis and include copies of tests, office notes, blood tests and imaging reports for the past 18 months. Be sure to include any records that document and support the medical diagnosis, such as history, 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.

Section 5 – PHYSICIAN / HOSPITAL / CLINIC CERTIFICATION

Please return this completed authorization and any attachments to the applicant at the address on page 3.

SS# _____/_____/_____

SECTION 4 – EMPLOYEE DISABILITY INFORMATION – cont.

To be completed by Physician

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:

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: (____) _____

F 0 $

SS# _____/_____/_____

Disability Retirement Application
Part V

JOB DESCRIPTION (ERS, PSERS, & GJRS ONLY)
HUMAN RESOURCES DIRECTOR

GENERAL INFORMATION INSTRUCTIONS

Type or print using black ink.
Complete all appropriate information.
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: _____
(Suffix, Last, 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 Signature _____

Title _____ Date _____

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

Email Address: _____

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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.

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 11 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.