Employees' Retirement System of Georgia

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ers.ga.gov

Public School 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.

Note: If you terminate employment before your disability application is received and acknowledged by ERSGA, you are not eligible for disability retirement.

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 PSERS
- 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 PSERS 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 7 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

Public School Employees Retirement System

Disability Retirement Application

Part I

General Instructions

- This Monthly Retirement Application may be used only for the Public School Employees Retirement System (PSERS).
- 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 15, 16, 17, and 20.
- Please note that page 18 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 19.
- The IRS form on page 21 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 25).

Privacy Note
IRS regulations require ERSGA to obtain the social security number of any member before processing their 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 ERSGA 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, you can download a PSERS Service Retirement Application from our website.

Disability Retirement Information

- 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 PSERS Employment

After receiving your retirement application, ERSGA will contact your PSERS employer for the alternative position form. If your application is approved by the ERSGA Medical Board, you must terminate from PSERS 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 PSERS 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 7 months
    - If you retire under Disability Retirement there are no age limitations. Otherwise, you must be at least age 45 or older

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.

The one exception is if you are unmarried at the time of retirement but later marry, you may elect a Joint & Survivor option with your new spouse as primary beneficiary; however you must make this choice in writing within 6 months after your marriage. Your benefit will reduce, but you can leave a lifetime monthly benefit to your new spouse.

Beneficiaries

- Primary Retirement Beneficiary(ies):
    - If you choose the Maximum Plan or Option B Period Certain at retirement, you may change your Primary Beneficiary(ies) at any time.
    - If you choose Option A Survivor Benefit, 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.
- 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.

Part I

Instructions for Forms and Acknowledgements

The following pages contain instructions for completing the forms in the *Forms and Acknowledgements* section beginning on page 14. The instructions will contain the name of the form at the top of the page, as well as the page number where the form can be found.

Please do not include this section when sending your completed retirement application forms to ERSGA.

Disability Retirement Application Form: Page 14

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

Date of Birth and Social Security Number (SSN)
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.

Current Employer (School System)
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.

Eligibility for Disability Retirement
You must be an active PSERS 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 at least 15 years of Creditable Service.

Retirement Options Form: Page 15

Maximum Plan: This option provides the highest, lifetime monthly benefit to you. 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 A: These options provide a reduced monthly benefit for your lifetime and a survivor benefit at your death. If your beneficiary predeceases you, your monthly allowance will terminate at your death. (Multiple beneficiaries will receive partial amounts based on age.)

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

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

Option A(c): Option A(c) 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 A(c), please visit our self- service website or request an estimate before choosing. The most common choices for Option A(c) 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.

Max Amount to Beneficiary*: If Option A(a) 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.

Option B: Under this option you will be paid a monthly benefit for the guaranteed payment period you select (5, 10, 15, or 20 years) or for your lifetime, whichever is longer. Upon your death, any payments remaining payable under the guaranteed period will be paid to your beneficiary.

5 Years (60 Payments)
10 Years (120 Payments)
15 Years (180 Payments)
20 Years (240 Payments)

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).

***Note:** To ensure compliance with IRS requirements for qualified plans, retirees might not be eligible to designate the full 100%retirement benefit under Option A(a) if they elect a non-spouse beneficiary who is more than ten years younger than the member or 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 A(c) Max Amount to Beneficiary.

Naming Your Retirement Allowance Beneficiaries Form: Page 16

- You may name one or more primary 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.

If you are unmarried at the time of retirement but later marry, you may elect a Joint & Survivor option with your new spouse as primary beneficiary; however you must make this choice in writing within 6 months after your marriage. Your benefit will reduce, but you can leave a lifetime monthly benefit to your new spouse.

Maximum and Option B Period Certain (5, 10, 15, & 20 years)

- 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 multiple beneficiaries, you may designate the percentage you want each beneficiary to receive. Total must equal 100%.

Options A(a), A(b), & A(c)

- 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 you were unmarried at the time of retirement.

*To ensure compliance with IRS requirements for qualified plans, retirees might not be eligible to designate the full 100%retirement benefit under Option A(a) 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 under Option A(c).

Direct Deposit Information: Page 17

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 17. Starter checks will not be accepted.

   Savings: Attach a savings deposit slip or authorization letter to the form page 17.

   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.

O.C.G.A. § 50-36-1(f) Affidavit – Page 18

ERSGA 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(f)

O.C.G.A. § 50-36-1(f) requires that all applicants for a public benefit complete signed and sworn affidavits, and provide at least one secure and verifiable document. 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)

Income Tax Withholding Form: Pages 20 – 24

- 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:
  - Check one box indicating your filing status in Section 2
  - Fill in the number of allowances
  - You may specify an additional dollar amount to be withheld on Section 4
- The amount of taxes based on your filing status and allowances plus the additional amount you list will be withheld from your retirement benefit

Federal Withholding

- If you **do not** wish to have federal taxes withheld, write "No Withholding" in the space underbox 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.

Part I

Retirement Forms and Acknowledgements

Employees' Retirement System of Georgia

F 1 $ P R S

PSERS Disability Retirement Application

Your Information

Name: ______________________________

Date of Birth: ______________ SSN: ______________

Mailing Address: ______________________________

City: ______________ State: ________ Zip: ________

Email address: ______________________________

Home Phone: ______________ Cell Phone: ______________

Marital Status (check one): ◯ Unmarried ◯ Married ◯ Widowed ◯ Divorced

If married, Spouse's name: ______________________________

Current Employer (School System): ______________________________

Position Title: ______________________________

Effective Retirement Date:

1st day of: Month ______________ Year ________

Disability applicants must complete Parts I through V.

Monthly Retirement Allowance Options

Please check only <u>one</u> box below to indicate your choice of monthly retirement allowance option. If you make a mistake, write your initial next to the correct choice. You may reference page 8 of this application, your estimate, the handbook, or Option Chart for additional information regarding the options.

- ◯ **Maximum Plan:** Benefits cease after my death.

Option A Joint & Survivor*:* I will be paid a monthly benefit for my lifetime. Upon my death, my named living primary beneficiary will receive a lifetime monthly benefit based on the choice I select below:

- ◯ **Option A(a) 100% Joint & Survivor:** At my death, my beneficiary will receive the same amount I received as a monthly benefit.
- ◯ **Option A(b) 50% Joint & Survivor:** At my death, my beneficiary will receive half of the amount I received as a monthly benefit.

Option A(c): A highly individualized method of payment. Choose one:

- ◯ ***Flat Amount to Beneficiary:*** I want my named primary beneficiary to receive $ ________ per month after my death.
- ◯ ***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 A(a) 100% Joint & Survivor is unavailable. If Option A(a) is available, ERSGA will process my application under Option A(a).

Option B Period Certain: I will be paid a monthly benefit for the guaranteed payment period I choose below, or for my lifetime, whichever is longer. Upon my death, any payments remaining payable under the guaranteed period will be paid to my beneficiary.

- ◯ **5 Years (60 Payments**)
- ◯ **10 Years (120 Payments**)
- ◯ **15 Years (180 Payments**)
- ◯ **20 Years (240 Payments**)

Initial ________________ Last four digits in SSN ________________ Date ________________

Primary Beneficiary(ies) for Retirement Benefits

- **Maximum Plan or Option B: Period Certain (5, 10, 15, 20):** Any person, estate or organization may be listed.
- **Option A(a), A(b), or A(c):** Any living person may be listed. If multiple beneficiaries are listed, 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, an organization, or multiple beneficiaries listed as Primary

If the Primary Beneficiary I designated above is deceased at my death, I 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: ______________________

Initial ______________ Last four digits in SSN ______________ Date ______________

Employees' Retirement System of Georgia

B2$PRS

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 ____________

Employees' Retirement System of Georgia

E 6 $ P R S

O.C.G.A. § 50-36-1(f) Affidavit

Attach a clear, legible copy of the secure and verifiable document or photo ID

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

- ◯ I am a United States citizen.
- ◯ I am a legal permanent resident of the United States.
- ◯ 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(f) with this affidavit. The secure and verifiable document provided to ERSGA with this affidavit can best be classified as:

____

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: ______________

Applicant Signature: ______________________________

Applicant Name (printed): ______________________________

Subscribed and sworn before me on this, the

____________ day of ______________________ 20 ____

Notary Public Signature: ______________________________

My Commission expires: ______________________

Note: This affidavit must have a notary signature and stamp or embossment and a copy of the secure and verifiable document or photo ID, as referenced in the Residency Affidavit Acceptable Documents list, returned to ERSGA with this application. Do not send your original ID.

Acknowledgement of Member

My employment with the state will terminate (or terminated) on ________________.
mm/dd/yyyy

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 ERSGA 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 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 your online account on our website: 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.

Note: If a Member who is receiving disability benefits is engaged in or is able to engage in a gainful occupation, their Disability Retirement may cease or be reduced. ERSGA performs audits of disability retirees on behalf of PSERS to determine continued eligibility for disability retirement benefits.

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 25 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 canceled and the option I chose at retirement can only be changed under very specific, life-changing circumstances as specified in this application.

Applicant Signature: ____

Last 4 digits of SSN: ________________ Date: ____________________

Georgia State Income Tax Withholding

1. ◯ I do not want Georgia state tax withheld from my benefit payment. (Do not complete lines 2, 3, or 4.)
2. 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 4.)

   Filing Status (choose one):

   ◯ Single

   ◯ Head of Household

   ◯ Married Filing Separately

   Married Filing Jointly:

   ◯ One Spouse Working

   ◯ Both Spouses Working

3. Exemptions: I claim ______ total allowances.

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

Initial ____________ Last 4 digits of SSN ____________ Date ________________

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

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 checking the box in the *No withholding* section. Then, complete Steps 1(a), 1(b), 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. Are submitting this form after the beginning of the year;

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

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

4. Have changes during the year in your marital status, number of pensions/jobs for you (and/or your spouse if married filing jointly), number of dependents, or changes in your deductions or credits.

TIP: Have your most recent payment statements/pay stubs from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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, check the box in the *No withholding* section. See Pub. 3920, Tax Relief for Victims of Terrorist Attacks, for more details.

Specific Instructions

Submit a **separate Form W-4P** for each pension, annuity, or other periodic payments you receive.

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

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

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

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

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

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

Example 4. Alex, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Alex also has a job that pays $25,000 a year and another pension that pays $20,000 a year. Alex 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 Alex also has $1,000 of interest income, which he entered on Form W-4, Step 4(a), he 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). He 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.

CAUTION ***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.*

CAUTION ***Social security number and other requirements for credits and deductions.*** *You (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits and deductions. For additional eligibility requirements for these credits and deductions, see Pub. 501, Dependents, Standard Deduction, and Filing Information.*

Specific Instructions *(continued)*

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.

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 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 17, if you expect to claim deductions other than the basic standard deduction on your 2026 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 qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors.

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 when you file your tax return.

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 2026, your current withholding election (or your default rate) remains in effect unless you submit a new Form W-4P.

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.

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

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1	Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.		
a	**Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000	**1a**	$
b	**Qualified overtime compensation.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to $12,500 ($25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation	**1b**	$
c	**Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000	**1c**	$
2	Add lines 1a, 1b, and 1c. Enter the result here	**2**	$
3	**Seniors age 65 or older.** If your total income is less than $75,000 ($150,000 if married filing jointly):		
a	Enter $6,000 if you are age 65 or older before the end of the year	**3a**	$
b	Enter $6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment	**3b**	$
4	Add lines 3a and 3b. Enter the result here	**4**	$
5	Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information	**5**	$
6	**Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:		
a	**Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income	**6a**	$
b	**State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately)	**6b**	$
c	**Home mortgage interest.** If your mortgage indebtedness is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums)	**6c**	$
d	**Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income	**6d**	$
e	**Other itemized deductions.** Enter the amount for other itemized deductions	**6e**	$
7	Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here	**7**	$
8	**Limitation on itemized deductions.**		
a	Enter your total income	**8a**	$
b	Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9	**8b**	$
9	Enter: • $768,700 if you're married filing jointly or a qualifying surviving spouse • $640,600 if you're single or head of household • $384,350 if you're married filing separately	**9**	$
10	If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here	**10**	$
11	**Standard deduction.** Enter: • $32,200 if you're married filing jointly or a qualifying surviving spouse • $24,150 if you're head of household • $16,100 if you're single or married filing separately	**11**	$
12	**Additional standard deduction.** If you (or your spouse) are 65 or older. Enter: • $2,050 if you're single or head of household • $1,650 if you're married filing separately • $1,650 if you're a qualifying surviving spouse or you're married filing jointly and one of you is under age 65 • $3,300 if you're married filing jointly and both of you are age 65 or older	**12**	$
13	**Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to $1,000 ($2,000 if married filing jointly)	**13**	$
14	Add lines 12 and 13. Enter the result here	**14**	$
15	Add lines 11 and 14. Enter the result here	**15**	$
16	If line 10 is greater than line 15, subtract line 11 from line 10 and enter the result here. If line 15 is greater than line 10, enter the amount from line 14	**16**	$
17	Add lines 2, 4, 5, and 16. Enter the result here and in Step 4(b) of Form W-4P	**17**	$

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

Part II - Instructions

Sections 1 & 2: Employee General Information / Disability Information

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 left corner of every page.

Section 3: Employee Request for Information

Please list only physicians (including specialists), hospitals, or clinics from which you are requesting medical information relating to your disability. Include:

- Name of physician, hospital, or clinic
- Complete address with zip code
- Phone numbers

If you need additional space, please attach a separate sheet(s).

Important: 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

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

SSN: ______________________________

B 3 $ P R S

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: ______________________________

Last Name, Suffix: ______________________________

First Name: ______________________________ Middle Initial: ________

Street Address: ______________________________

City: ______________________________ State: __________ Zip: ______________

Phone: ____________________ Email: ______________________________

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: ____________________

SSN:________________________

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, or diseases prevent you from performing these duties?

Explain what you feel or experience.

When did these first become known to you? Date: ________________________

When did these first interfere with your job performance? Date: ________________________

List any other health problems you have.

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

SSN:______________________

Section 2: Employee Disability Information – Continued

Activities of Daily Living:

Are you currently having problems completing your daily routine? (Please check 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:

SSN:__________________________

Section 2: Employee Disability Information – Continued

Activities of Daily Living, continued:

How do you get around? ◯ 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

SSN: ____________________

Section 3: Employee Request for Information

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).

Important: Your disability application will not be accepted until we have received the disability related reports from all of the providers listed below.

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 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 invalidated.

I understand that I am not allowed to return to my work duties while this application is in process, and 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)

Employees' Retirement System of Georgia

Two Northside 75, Suite 300
Atlanta, GA 30318-7778
Local 404.350.6300
Tooll Free 800.805.4609
ers.ga.gov

Disability Retirement Application
Part III

Employer's Disability Report

Section 1: Employee Information

- To be completed by the employee
- Type or print. Blue ink is preferred
- Write your Social Security number at the top 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. You can download a copy from the Employer Forms section of the ERSGA website.

SSN: ____________________

Disability Retirement Application Part III

Employer's Disability Report

Section 1: Employee Information

Last Name, Suffix: ____________________

First Name: ____________________ Middle Initial: ____

Employee ID #: ____________________ Requested Retirement Date: ____________________

Mailing Street Address: ____________________

City: ____________________ State: ____ Zip: ____________

Section 2: Human Resources Director Information

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

Employer Mailing Address: ____________________

City: ____________________ State: ____ Zip: ____________

Employee's Current Position Title: ____________________ Effective date: ____________________ (mm/dd/yyyy)

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, beginning date of absence: ____________________ (mm/dd/yyyy) Ending date: ____________________ (mm/dd/yyyy)

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

SSN: ____________________

Section 2: Human Resources Director Information - continued

Has the license or certification been suspended or revoked? ◯ Yes ◯ No

If Yes, date of suspension or revocation: ____________________ (mm/dd/yyyy)
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 Signature: ____

Title: ____ Date: ____________________

Phone Number: ____________________ Fax Number: ____________________

Email: ____

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?

Begin date: ______________________ End date: ______________________
(mm/dd/yyyy) (mm/dd/yyyy)

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 Signature: ____

Title: ____ Date: ______________

Phone Number: ____________________ Fax Number: ____________________

Email Address: ____

Employees' Retirement
System of Georgia

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ers.ga.gov

Disability Retirement Application
Part IV

Employee's Request for Disability Information from Physician/Physician's Report

PART IV - Instructions

Section 1: Employee General Information

- Type or print. Blue ink preferred.
- Attach a copy of your job description.
- Type or 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.

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.

Sign and date this authorization.

Important: 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 3 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.

SSN: ____________________

E 9 $ P R S

Disability Retirement Application Part IV

Employee's Request for Disability Information From Physician/Physician's Report

Section 1: Employee General Information to be completed by Employee

Last Name, Suffix: ____________________

First Name: ____________________ Middle Initial: ______

Mailing Street Address: ____________________

City: ____________________ State: ______ Zip: ____________

Position Title: ____________________

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 Last Name, Suffix: ____________________

First Name: ____________________ Middle Initial (if applicable): ______

Physician Mailing Address: ____________________

City: ____________________ State: ______ Zip: ____________

Email: ____________________

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)

SSN: ____________________

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: 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? ______________________________
(mm/dd/yyyy)

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.

SSN: ______________________

Section 4: Employee Disability Information 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: 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, or 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: ______________________

Employees' Retirement
System of Georgia

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

Disability Retirement Application
Part V

Job Description

SSN: ____________________

F 0 $ J R S

Disability Retirement Application
Part V

Job Description
Human Resources Director

General Information Instructions

Type or print. Blue ink is preferred.
Complete all appropriate information. Attach a copy of the job description.
Write the member's Social Security Number in the top left corner of this page.

Employee Information

Last Name, Suffix: ____________________

First Name: ____________________ Middle Initial: _____

Mailing Street Address: ____________________

City: ____________________ State: _____ Zip: ____________________

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 Resource Director Information

Human Resources Director's Signature: ____________________

Title: ____________________ Date: ____________________

Phone Number: ____________________ Fax Number: ____________________

Email: ____________________

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