Teachers' Retirement System of Alabama

Retirement Application Packet

Part I

This packet includes the following documents:

- **Form 10 - Application for Retirement**
- **PEEHIP Insurance Authorization Form**
- **Direct Deposit Authorization Form**

The Application for Retirement must be received at least 30 days and not more than 90 days prior to the effective date of retirement. The effective date of retirement must be the first day of a month.

P. O. Box 302150
Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
www.rsa-al.gov

Checklist for TRS Retirement Application

Congratulations! You are about to begin what we hope will be a long and happy retirement. This retirement packet, Part I, contains the information and forms you need to initiate the retirement process. Once we receive your completed Part I forms, you will be sent Part II: Retirement Benefit Option Selection and Tax Forms Packet. The retirement process is not complete until you have returned the Benefit Option Selection Form.

To Apply for Your TRS Retirement Benefit:

- ☐ Complete the Form 10 - Application for Retirement and detach it.
- ☐ Have your employer certify the Employer Certification portion of the Form 10.
- ☐ If you are applying for disability retirement, a Report of Disability Packet must be completed by you and your doctor and received by the TRS along with your Form 10 at least 30 days and not more than 90 days prior to the effective date of retirement.
- ☐ Complete the PEEHIP Insurance Authorization Form, which can be found on the back of the Application for Retirement.
- ☐ Complete the front page of the Direct Deposit Authorization form, then take or mail the form to your financial institution. This form will authorize the Teachers' Retirement System to remit and credit your benefit directly to your bank account and eliminate the possibility of your check being lost or stolen.
- ☐ Send the Form 10 - Application for Retirement, the PEEHIP Insurance Authorization form, and any other completed forms to: TRS, P. O. Box 302150, Montgomery, AL 36130-2150. **Your Application for Retirement must be received by the TRS at least 30 days and not more than 90 days prior to the effective date of retirement.** The effective date of retirement must be the first day of a month.
- ☐ **Once we receive your Application for Retirement (Part I), you will be sent Part II: Retirement Benefit Option Selection and Tax Forms Packet. This packet will contain a retirement allowance report. All TRS retiring members automatically receive the Maximum Benefit unless a Benefit Option is chosen. Your Benefit Option Selection form must be received by the TRS prior to the effective date of retirement. Otherwise, by law you will automatically receive the Maximum Benefit which is irrevocable.**
- ☐ Make sure that the TRS has your current home address. If your home address should change, notify the TRS in writing. Important information regarding your retirement will be mailed from time-to-time directly to your home address.

Should you desire to cancel your Application for Retirement, written notice must be given to the TRS prior to your effective date of retirement. Failure to give timely notice will result in an irrevocable application.

Your retirement account will be audited both at the time of retirement and after all contributions have been remitted. Discrepancies between the contributions certified on your Application for Retirement and the contributions remitted to the TRS may affect your retirement benefits and/or your eligibility for retirement.

For further information about the retirement process, please read your TRS Member Handbook. We also encourage you to check out our website at www.rsa-al.gov. If you have questions, feel free to contact one of our retirement counselors.

As always, we will do our best to help you and all other TRS retirees enjoy their retirement years.

TRS Form 10 09/08

Application for Retirement

Teachers' Retirement System of Alabama

P.O. Box 302150
Montgomery, AL 36130-2150
334-517-7000 or 877-517-0020
www.rsa-al.gov

Member Information

Name _____ Soc. Sec. No. _____

Home Address _____ Date of Birth _____
Street or P. O. Box

_____ Home Phone ( ) _____
City State Zip

Employer _____ Work Phone ( ) _____

Type of Retirement (Check One): ☐ Service ☐ Disability (Report of Disability form must also be submitted.)

Date of Retirement (This date is always the first of a month.) _____ 1, 20 ___
Month Year

Name of bank/financial institution to which retirement benefit is to be deposited _____
(The properly completed Direct Deposit Authorization form must be submitted to the TRS to authorize remittance to the bank/financial institution.)

Beneficiary Designation

I am designating the following beneficiary to receive any benefit due at my death _____

Relationship to me _____ Date of Birth _____

Social Security Number _____

In the event the designated beneficiary listed above is different from that listed on my active account, I desire the change to be effective **(Check One)**:

☐ Upon the duly executed completion of this application filed through the TRS with the Board of Control.
☐ On the date my retirement benefit becomes due and payable.

Member Authorization

Signature of Applicant _____ Date _____

STATE OF _____ , COUNTY OF _____

On this _____ day of _____ , 20 __ , personally appeared before me, the above named individual and made oath that the statements made are true.

Notary _____

My Commission Expires: _____

Employer Certification

Date on which service of applicant will terminate _____

Closing date of last payroll of applicant _____

Job classification _____

Contract salary for full year _____

Total contributions (to be) deducted
for the current scholastic year _____

Total contributions (to be) deducted
after the current scholastic year _____

Days worked/days contracted for the current contract period _____

Please certify deductions for last 7 months for which contributions will be submitted.

Jul	_____	Jan	_____
Aug	_____	Feb	_____
Sep	_____	Mar	_____
Oct	_____	Apr	_____
Nov	_____	May	_____
Dec	_____	Jun	_____

Total accrued and unused sick leave days at date of retirement for which **no lump sum payment will be made** _____

Signature of Authorized Official: _____ Work Phone: ( ) _____

Employing Institution: _____ Date: _____

Please complete the information on the reverse side of this form.

Insurance Authorization Form

Public Education Employees' Health Insurance Plan (PEEHIP)

Part I: Members Currently Enrolled

Members currently enrolled in Hospital/Medical coverage with PEEHIP check the box which applies:

☐ I wish to continue my Hospital/Medical coverage with PEEHIP.*

☐ I do not wish to continue my Hospital/Medical coverage with PEEHIP

Requested Date of Cancellation: ☐ Date of Retirement ☐ End of Earned Allocations

Signature of Retiree _____ Date _____

Part II: Member Combining Allocations with Spouse

Members combining allocations with spouse check all that apply:

☐ I am presently transferring allocation to retired spouse contract number _____ and wish to continue in that manner.

☐ I am presently receiving allocation from my active spouse and wish to continue in that manner.

☐ I am presently transferring allocation to active spouse contract number _____ and understand that I must enroll in the Hospital Medical Plan in my name and receive my active spouse's allocation.**

**PEEHIP policies require the retiree to enroll in insurance in his/her name if combining allocation with active spouse. Enrollment application will be sent to retiree to enroll.

Spouse retiree date (if applicable) _____

Employer Certification (to be completed by payroll/insurance official)

The final payroll deduction of $ _____, will be deducted for _____ (Month) coverage.

This employee is a _____ (9, 10, 11, 12) month employee.

Signature of Authorized Official _____ Date _____

Part III: Optional Coverage

Persons who are not insured on a PEEHIP Hospital Medical plan and are only enrolled in the Optional coverages (Dental, Cancer, Indemnity, and Vision) can continue all four coverages or drop **two** optionals at date of retirement. The retired state allocation will pay the premium for **two** of the optionals without a payroll deduction for those retired members enrolled in only the optional coverages. If you are not currently enrolled in optional coverage, you can only enroll during the Open Enrollment Period. *

If you are only enrolled in the Optional coverages and wish to drop down to two plans, please indicate which two plans you wish to **keep** on your date of retirement. If you wish to keep all four optionals, mark "all."

☐ Cancer ☐ Indemnity ☐ Dental ☐ Vision ☐ All

Signature of Retiree _____ Date _____

Part IV: Non-Participating System

Persons whose public education employer does not participate in PEEHIP Hospital/Medical will be provided with information and an enrollment form about PEEHIP. If you wish to enroll, complete an enrollment form and submit it with the payment for the first month's premium no later than your effective date of retirement. If you **are not** enrolled in your employer's Hospital/Medical coverage, you and your dependents will be required to serve a 270-day waiting period on all pre-existing conditions with PEEHIP.

Part V: Vested Members Not Currently Enrolled

If you are **not** currently employed in public education in Alabama, you are eligible to enroll in the Hospital/Medical insurance through PEEHIP on your date of retirement. You and your dependents will be required to serve a 270-day waiting period on all pre-existing conditions unless proof of previous coverage is received and approved. Please indicate your intentions below and an enrollment form will be provided to be completed and returned no later than your date of retirement with the payment for the first month's premium.

☐ I wish to enroll in the Hospital/Medical coverage with PEEHIP effective the date of my retirement.

☐ I do not wish to enroll in the Hospital/Medical coverage with PEEHIP.

Part VI: PEEHIP Subscriber Certification

I agree to have premiums deducted from my retirement check for any months that are due but were not deducted.

Signature of Retiree _____ Date _____

* To members enrolled in both the PEEHIP Hospital/Medical coverage and one or more optional coverages: A member cannot drop optional coverages (Dental, Cancer, Indemnity, Vision) until the Open Enrollment Period. Hospital/Medical coverage will be dropped the first day of the month following receipt of notification. Optional coverages can only be added during the Open Enrollment Period.

RSA DDR (07/12)

Direct Deposit Authorization
Retirement Systems of Alabama

P.O. Box 302150
Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
www.rsa-al.gov

The retiree or beneficiary of a deceased retiree must complete the front page of this form. Then take or mail the form to your financial institution so they may verify the information on the front, **complete the information on the reverse side**, and agree to the Master Agreement.

Benefit Recipient Information

Social Security Number _____

Benefit Recipient (Please check one):
- ☐ Retiree
- ☐ Beneficiary of Deceased Retiree/Member

Name _____

Address _____ Daytime Phone No. _____

_____ Email Address _____

_____

Indicate the system(s) from which you would like your benefit(s) direct deposited.

☐ Teachers' Retirement System ☐ Employees' Retirement System ☐ PEIRAF ☐ Judicial Retirement Fund

☐ RSA-1 *(Annual or Monthly Distribution Only)*

Joint Financial Institution Account Holder's Certification:

I agree to notify the Retirement Systems of Alabama (RSA) immediately of the death of the recipient of the retirement benefits being deposited to this joint financial institution account, and to return all payments to the RSA that are deposited to this account after said death. The RSA will determine and pay any survivor benefits. The RSA is authorized to make necessary debit entries to this joint account for any credits that were made in error.

Name(s) of Joint Financial Institution Account Holder(s)	Signature(s) of Joint Financial Institution Account Holder(s)
_____	_____
_____	_____
_____	_____

Date _____

Benefit Recipient Certification:

Each benefit payment is to be credited to my account at the financial institution specified on the reverse side of this form and such payment will be in full payment, satisfaction, and discharge of the amount then falling due and payable to me on account of such payments.

If my death occurs prior to the due date of any payment made by the RSA in compliance with this request or if adjustments are required for any credit entries to my account, I authorize the RSA to make the necessary debit entries to my account. I hereby reserve the right to revoke or cancel this request, such revocation or cancellation to take effect within 30 days of receipt of written notice by the RSA.

I authorize my payment to be sent to the financial institution named on the reverse side of this form to be deposited to the designated account.

Signature of Benefit Recipient _____ Date _____

Financial Institution Information (to be completed by a representative of the financial institution)

Name of Benefit Recipient _____ Soc. Sec. No. _____

Depositor Account No. _____ Bank Routing No. _____

Name of Financial Institution _____ Type of Account: ☐ Checking ☐ Savings

Mailing Address _____

_____

Name(s) of Person(s) on this Account: _____

_____

_____

Financial Institution Certification and MASTER AGREEMENT:

In accordance with the provisions of Section 3.6.4 of the 2012 National Automated Clearing House Association (NACHA) Operating Rules and Guidelines, both the Retirement Systems of Alabama (RSA), as the Originator, and the above named Financial Institution consider the following to be the Master Agreement, as defined by the NACHA Operating Rules and Guidelines, and agree that it is to be applicable to all payments sent by the RSA to the Financial Institution for the benefit of all benefit recipients having accounts with the Financial Institution.

In consideration of the RSA making benefit payments in accordance with this Direct Deposit Authorization without requiring proof that the retiree/beneficiary identified on this form is alive on the date on which such benefits are paid and are credited to his or her account, the Financial Institution agrees to repay and refund to the RSA, on demand, the full amount of any payments made to and received by the Financial Institution after the date of death of the benefit recipient, regardless of whether the account listed on this Direct Deposit Authorization contains sufficient funds for the refund. The Financial Institution further agrees to accept the certification of the RSA as to the date of death of such payee as sufficient evidence in accordance with Section 2.10 of the 2012 NACHA Operating Rules and Guidelines.

I, the undersigned, confirm that the identity of the above named retiree/beneficiary, account number, and type are true and accurate. As the representative of the above named Financial Institution, I certify that the Financial Institution agrees to receive and deposit the identified payments in accordance with the Master Agreement and pursuant to Section 3.6.4 of the 2012 NACHA Operating Rules and Guidelines, and that the Master Agreement is applicable to all payments sent by the RSA to the Financial Institution for the benefit of the retiree/beneficiary.

Name of Representative _____

Signature of Representative _____ Date _____

Telephone Number _____

Note: Direct Deposit Authorization forms that are processed after the 14th of each month will become effective the following month.

Please return completed form to:

The Retirement Systems of Alabama
P.O. Box 302150
Montgomery, Alabama 36130-2150