

## Dear Member:

This is your application for disability retirement. Please read all directions carefully before completing the attached form.

### I. When to File an Application for Disability Retirement

Your application for disability retirement should be forwarded to TCRS 60 – 90 days prior to your last paid day of service. The last paid day of service is either your last day of employment or the last day for which you are paid annual, sick leave, and/or sick leave bank. However, your application cannot be filed more than 150 days prior to your last paid day of service.

**Appropriate forms for continuation of insurance and withholding of income tax should accompany your retirement application. Refer to State of Tennessee Group Insurance handbooks for eligibility requirements for continuation of insurance.**

### II. Directions for Completing Part I of the Disability Retirement Application

- A. Please type or print (in black ink) all information.
- B. Please check the type of disability retirement desired. You must include the following forms:
  - 1. Statement of Disability
  - 2. Vocational History
  - 3. Medical Records Release Authorization
  - 4. Attending Physician's Report
  - 5. Report of Accidental Disability (if applicable)

Forms may be obtained from the TCRS office or on the Treasury Department website at [www.treasury.state.tn.us/tcrs](http://www.treasury.state.tn.us/tcrs).

**Medical and/or psychological documentation of total and permanent disability must accompany your application. This documentation includes office notes and summaries, hospital admission and discharge summaries, and test results. It is your responsibility to obtain this vital information.**

- C. Complete all requested information for Sections 1-8a. In Section 8, the date terminated is the last working day (including all annual and/or sick days) for which you are paid. The effective date of retirement is the day immediately following the last paid day, or the first day of eligibility for benefits. Payment will be made retroactive to your date of retirement provided that no benefit may become effective more than 150 days prior to receipt of the application in our office.
- D. Section 9 explains the benefit plans available. You must select one benefit plan.
- E. Designation of your beneficiary should be made in Section 10. If you select the Regular Plan, you may designate one individual or your estate as beneficiary. If you select Option I – IV, you must designate one individual as beneficiary. Proof of this beneficiary's birth date should be included. Your designated beneficiary must also sign the application in Section 10.
- F. Please attach a voided check in Section 11 or give us your savings account information. As required by State law, TCRS monthly benefits will be deposited directly to the checking or savings account indicated on your retirement application. Payments will be available on the last working day of each month. You will be notified in writing of any changes made to the amount of your net benefit. All correspondence and year-end statements will be mailed to your home address.
- G. Your application must be signed and notarized.

### III. Part II Must be Completed by Your Employer.

Submit your notarized application to your employer to complete Part II. Upon completion, the application should be returned to the Tennessee Consolidated Retirement System. If you have been out of service for more than six (6) months, Items 1-3 of Part II do not need to be completed; however, unused sick days (Item 4) must be certified by your employer.

### IV. Acknowledgment

All applications will be acknowledged by letter after we receive them. If you do not receive an acknowledgment within two (2) weeks, please contact our office.

**If you should return to employment on a part-time or full-time basis, you should contact the TCRS Disability staff for current earnings limitations.**

If you have any questions regarding your application for disability retirement, call (615) 253-8693 or write our office.

**TENNESSEE CONSOLIDATED RETIREMENT SYSTEM  
502 DEADERICK STREET • NASHVILLE, TN 37243-0201**

**APPLICATION FOR DISABILITY RETIREMENT BENEFITS**

**PART I - TO BE COMPLETED BY APPLICANT (Type or print legibly in BLACK ink)**

Please check one:     Ordinary Disability Retirement     Accidental Disability Retirement (*on-the-job accident only*)

|   |  |  |   |   |  |
|---|--|--|---|---|--|
| 1. SOCIAL SECURITY NUMBER _____/_____/_____   |  | 2. BIRTHDATE: (Month/Day/Year) _____/_____/_____ |   | 3. SEX: <input type="checkbox"/> M <input type="checkbox"/> F |  |
| 4. NAME: LAST   |  | FIRST  |   | MIDDLE MAIDEN   |  |
| 5. ADDRESS: STREET (rural route)  |  | CITY   |   | STATE ZIP CODE  |  |
| 6. PHONE NUMBER: ( ) _____-_____  |  |  | 7. LAST EMPLOYER: Name of Department or Institution                         |   |  |
| 8. DATE EMPLOYMENT TERMINATED: (Month / Day / Year)<br>(Last paid work day or paid leave) _____/_____/_____ |  |  | 8a. EFFECTIVE DATE OF RETIREMENT: (Month / Day / Year)<br>_____/_____/_____ |   |  |

9. I hereby select one of the following benefit plans. (check one)

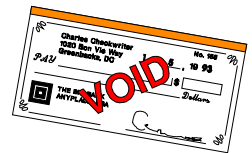
- REGULAR/MAXIMUM PLAN** - Monthly benefit payable to you for your life with all benefits ceasing at death. Any remaining balance of your accumulated contributions and interest will be paid to the surviving designated beneficiary in a lump sum.
- OPTION I** - Monthly benefit reduced from the regular plan. In the event of your death, your designated beneficiary will receive monthly benefits equal to yours, for his or her life. Should your beneficiary die before you, your monthly allowance will remain the same.
- OPTION II** - Monthly benefit reduced from the regular plan. In the event of your death, your designated beneficiary will receive fifty percent (50%) of your monthly benefit for his or her life. Should your beneficiary die before you, your monthly allowance will remain the same.
- OPTION III** - Monthly benefit reduced from the regular plan. In the event of your death, your designated beneficiary will receive monthly benefits equal to yours, for his or her life. Should your beneficiary die before you, your allowance will revert to the amount you would have received under the regular plan.
- OPTION IV** - Monthly benefit reduced from the regular plan. In the event of your death, your designated beneficiary will receive fifty percent (50%) of your monthly allowance for his or her life. Should your beneficiary die before you, your allowance will revert to the amount you would have received under the regular plan.

|   |  |                                       |  |                            |               |
|---|--|---------------------------------------|--|----------------------------|---------------|
| 10. As beneficiary under the benefit plan selected above, I designate ( <i>one individual or estate only</i> ): |  |                                       |  |                            |               |
| NAME: LAST  |  | FIRST                                 |  | MIDDLE MAIDEN              |               |
| BIRTHDATE: (Month/Day/Year) _____/_____/_____   |  |                                       | SEX: <input type="checkbox"/> M <input type="checkbox"/> F |                            | RELATIONSHIP: |
| SIGNATURE OF BENEFICIARY:   |  | BENEFICIARY'S SOCIAL SECURITY NUMBER: |  | DATE: (Month / Day / Year) |               |
|   |  | _____/_____/_____                     |  | _____/_____/_____          |               |

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11. Direct Deposit Information: (Direct deposit of pension benefits is required by State law.)

TCRS will deposit your monthly benefits directly to the bank account of your choice. **Tape a voided check in this area for direct deposit to your checking account.** If you want your benefit directly deposited into a savings account, complete the appropriate blanks below.



Savings Account # \_\_\_\_\_

Routing # \_\_\_\_\_  
(Contact your financial institution for the correct routing number.)

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Appropriate forms for continuation of insurance (if eligible) and withholding of income tax should accompany your retirement application.

I hereby certify that I have carefully completed and truthfully answered all questions contained herein to the best of my knowledge and belief. I further certify that I understand if I obtain part-time or full-time employment with an agency covered by the Tennessee Consolidated Retirement System (TCRS), I am required to notify the Tennessee Consolidated Retirement System and my benefit will be suspended except as provided by Part 8, Chapter 36 of Title 8 Tennessee Code Annotated. I further understand that receipt of disability benefits is subject to earnings limitations even if the employer is not covered by the TCRS.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF MEMBER

STATE OF TENNESSEE, COUNTY OF \_\_\_\_\_

Personally appeared before me the within named \_\_\_\_\_ who makes oath that he (or she) executed the foregoing instrument. This \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

(SEAL)

Notary Public \_\_\_\_\_  
My Commission Expires \_\_\_\_\_

**PART II – TO BE COMPLETED BY SUPERINTENDENT OR PAYROLL/PERSONNEL OFFICER**

*(If member has been out of service for more than six (6) months, Part II does not need to be completed. However, unused sick days must be certified.)*

- Member's last paid day of service, annual leave, sick leave, or sick leave bank. \_\_\_\_\_  
MONTH DAY YEAR
- Please list individually all payrolls the employee will appear on for his last three (3) months of service. If any salaries are estimated, indicate by marking (EST) and provide actual payroll information as soon as possible. Any longevity payments or career ladder payments should be included and **itemized** in the final salary amounts as well as payments for sick leave, vacation, annual days, or bonus pay (if applicable).

| BREAKDOWN OF FINAL SALARY |                |                 |        |                        |
|---------------------------|----------------|-----------------|--------|------------------------|
| Month                     | Payroll Period | Type of Payment | Amount | Employee Contributions |
|                           |                |                 |        |                        |
|                           |                |                 |        |                        |
|                           |                |                 |        |                        |
|                           |                |                 |        |                        |
|                           |                |                 |        |                        |
|                           |                |                 |        |                        |
|                           |                |                 |        |                        |
|                           |                |                 |        |                        |
|                           |                |                 |        |                        |

3a. Please indicate the total salary for the current year and the portion of the year the salary represents. If the current year is a partial year, also include the salary for the previous year.

Current fiscal year salary \_\_\_\_\_ Number of months included \_\_\_\_\_ Percentage Worked \_\_\_\_\_  
 Previous fiscal year salary \_\_\_\_\_ Number of months included \_\_\_\_\_ Percentage Worked \_\_\_\_\_

b. Indicate if member worked and was paid on:

- Fiscal year July 1 - June 30                       Academic year September 1 - August 31  
 Calendar year January 1 - December 31                       Other \_\_\_\_\_

4. Certify the number of unused sick days member has remaining effective \_\_\_\_\_ # of hours \_\_\_\_\_ or days \_\_\_\_\_  
 (Month/Day/Year)

How many sick days did this employee accumulate on an annual basis?  9  10  11  12

Signed \_\_\_\_\_  
 Superintendent or Certifying Officer

Address \_\_\_\_\_  
 \_\_\_\_\_

Department \_\_\_\_\_

Phone \_\_\_\_\_