PUBLIC EDUCATION EMPLOYEE
RETIREMENT SYSTEM OF MISSOURI

PO Box 268
Jefferson City, MO 65102-0268
(573) 634-5290 or
Toll Free: (800) 392-6848
Fax: (573) 634-7934
Email: psrspeers@psrspeers.org
Website: www.psrs-peers.org

FILING FOR DISABILITY RETIREMENT

Qualifications for disability retirement:

- Must be incapacitated due to a physical or mental disability that appears to be total and permanent
- Must be incapable of earning a livelihood in any occupation
- Must have a minimum of five years of service with PEERS
- Must be less than age 60
- Must be employed by an employer included in PEERS at the time the disability begins, or the disability occurs within one year after employment, and the condition causing your disability began prior to the termination of employment

Step 1

Complete and return your *Disability Retirement Application*.

Please note that the application is a two-page form. Both pages must be returned to PEERS.

The ***Disability Retirement Application*** should be filed as soon as you know you will be terminating your services with your employer or after the ending date of any leave of absence. Disability retirement can be made retroactive up to 60 days before the application filing date, but cannot become effective until your compensated employment or leave of absence ends.

Please note the following:

- **Last Date of Employment/Termination Date:** This means the date of your termination of employment with your employer, or if on leave of absence, the ending date of your leave, whichever is later.
- **Beneficiary Designation**: You must designate beneficiaries to become effective at your retirement date.

Failure to submit both pages of the *Disability Retirement Application* prior to the requested date of retirement will delay the effective date of retirement and cause you to lose one or more benefit payments.

Step 2

Complete and return the *Direct Deposit Authorization* form with a voided check.

Step 3

Submit proof documents.

Please make sure copies are readable.

- A copy of your birth certificate, issued by the city, county or state of birth (unless already submitted)

Step 4

Complete and return the IRS Form W-4P and *Missouri Tax Withholding Authorization* form.

Contact the appropriate taxing agency or a tax specialist if you have questions about your tax liabilities or tax withholding.

REMINDER

Purchases of service must be paid in full prior to the effective date of your retirement. Failure to complete payment on time will cause you to lose benefits or retire without the purchased service.

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DISABILITY RETIREMENT APPLICATION

This application *must* be filed with PEERS prior to your effective retirement date.

- **Please complete and return both pages of this application to PEERS at the address above.**
- Make sure you sign the application in Sections F and G on page 2.
- Please keep a copy for your records.
- PEERS will send an acknowledgement of your ***Disability Retirement Application***.

SECTION A – MEMBER INFORMATION

Member's First Name	Member's Middle Name	Member's Last Name

Member ID (or Last Four Digits of Member's Social Security Number)	Account ID

Mailing Address

City	State	ZIP	Telephone ( )

Email Address

SECTION B – LAST PEERS-COVERED EMPLOYMENT INFORMATION

Last PEERS-Covered Employer	Last Date of Employment/Termination Date

Additional PEERS-Covered Employer(s) for the Current School Year, if any	Last Date of Employment/Termination Date

Position Held

Description of Job Duties

SECTION C – EFFECTIVE DISABILITY RETIREMENT DATE

Your effective retirement date must be ***after*** your last date of employment/termination date. If you earn a full year of service with PEERS for the school year immediately before your retirement, the earliest your retirement can be effective is July 1.

I request my disability retirement be effective on: _____ (month) **1,** _____ (year)

SECTION D – DISABILITY INFORMATION

Date Disability Began:

(month) (day) (year)

Description of Disability

SECTION E – BENEFICIARY DESIGNATION

Primary Beneficiary

First Name	Middle Name	Last Name

Social Security Number				—			—					

Date of Birth	Relationship to You

Mailing Address

City	State	ZIP

First Contingent Beneficiary

First Name	Middle Name	Last Name

Social Security Number				—			—					

Date of Birth	Relationship to You

Mailing Address

City	State	ZIP

Second Contingent Beneficiary

First Name	Middle Name	Last Name

Social Security Number				—			—					

Date of Birth	Relationship to You

Mailing Address

City	State	ZIP

SECTION F – WORKING AFTER DISABILITY RETIREMENT

You must indicate your understanding of the following laws by signing below:
I understand that:

- Prior to age 60, my disability benefits will stop and I must notify PEERS if 1. I am employed in **any capacity** by a PEERS-covered employer, or 2. I am employed outside of PEERS and have earnings in excess of the substantial gainful activity limit for non-blind Social Security Disability Insurance (SSDI) benefits, which is set by the Social Security Administration. This amount is subject to change.
- After reaching age 60, I can work for PEERS-covered employers up to the 550-hour limit and my work outside of PEERS is unrestricted.

Member Signature (REQUIRED) **X**	Date

SECTION G – MEMBER CERTIFICATION

I understand that:

- Upon receipt of this application in the PEERS office, PEERS will contact my employer to verify my employment status.
- My beneficiary designation on this application becomes effective on my retirement date.
- Until I reach age 60, PEERS requires annual earned income verification for continued benefit eligibility. Until I reach age 60, I may also be required to provide medical certification of my disability status, possibly including examinations by physicians designated by PEERS.
- I must contact PEERS and my benefits will stop if I recover from my disability prior to age 60.
- To be eligible for disability benefits, I must be incapable of earning a livelihood in any gainful occupation. A gainful occupation is one that replaces not less than 75% of the average of my last three years of salary and is reasonably found in my geographic area as established by the U.S. Bureau of Labor Statistics.

I expressly waive all provisions of law forbidding any physician or person who has attended or examined me, or who may hereafter attend or examine me from disclosing any knowledge or information, which he or she thereby acquired, to PEERS.I also certify that the information given herein is true and correct.

Member Signature (REQUIRED) **X**	Date