PUBLIC SCHOOL 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 the Public School Retirement System of Missouri (PSRS)
- Must be younger than age 60
- Must be employed by an employer included in PSRS at the time the disability begins, or the disability occurs within one year after employment, and the condition causing your disability began prior to your termination of employment

Step 1 **Complete and return your *Disability Retirement Application*.**
Please note that the application is a three-page form. All three pages must be returned to PSRS.

File the ***Disability Retirement Application*** 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 *(Section B)***: This means the date your employment terminated, or if you are on a leave of absence, the ending date of your leave, whichever is later.
- **Physician/Facility Information *(Section E)***: You must list the names, addresses, telephone and fax numbers, and email addresses (if available) for your treating physicians and medical facilities.
- **Beneficiary Designation *(Section F)***: You must designate beneficiaries to become effective at your retirement date.

Failure to submit all three pages of the *Disability Retirement Application* prior to the requested retirement date will delay your effective retirement date and cause you to lose one or more benefits.

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 *Tax Withholding Authorization* form.**

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

Step 5 **Complete and return the *$5,000 Death Benefit Beneficiary Designation* form.**

REMINDER

You must pay in full for **service purchases** prior to your effective retirement date. 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 the Public School Retirement System of Missouri (PSRS) prior to your PSRS retirement date.

- **Please complete and return all three pages of this application to PSRS at the address above.**
- Make sure you sign the application in Sections G and H on page 3.
- Please keep a copy for your records.
- PSRS 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 PSRS-COVERED EMPLOYMENT INFORMATION

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

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

During the current school year, did you, or will you, work summer school?

☐ **YES** If yes, please provide Employer name:

☐ **NO**

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 PSRS 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 – PHYSICIAN/FACILITY INFORMATION

List names, complete addresses, telephone and fax numbers, and email addresses (if available) for all physicians/medical facilities recently consulted.

Physician/Facility Name

Mailing Address

City | State | ZIP

Telephone ( ) | Fax ( )

Email Address

Physician/Facility Name

Mailing Address

City | State | ZIP

Telephone ( ) | Fax ( )

Email Address

Physician/Facility Name

Mailing Address

City | State | ZIP

Telephone ( ) | Fax ( )

Email Address

SECTION F – 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 G – 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 PSRS if 1.) I am employed in any capacity by a PSRS-covered employer, and 2.) I am employed outside of PSRS and have earnings that are considered a livelihood as defined by PSRS. (PSRS currently considers a livelihood as earning $18,000 or more per year. This amount is subject to change.)
- After reaching age 60, I can work for PSRS-covered employers up to the 550-hour and 50% salary limits, and my work outside of PSRS is unrestricted.

Digital Signatures Not Accepted – Original (Written) Signature Required **X**	**Date**

SECTION H – MEMBER CERTIFICATION

I understand that:

- Upon receipt of this application in the PSRS office, PSRS 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, PSRS requires annual certification of my disability status and possibly examinations by physicians designated by PSRS.
- I must contact PSRS and my benefits will stop if I recover from my disability prior to age 60.

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 PSRS.

I certify that I am incapable of earning a livelihood as defined by PSRS. I also certify that the information given herein is true and correct.

Digital Signatures Not Accepted – Original (Written) Signature Required **X**	**Date**

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Notice to Healthcare Provider: If a fee applies, please include a copy of the statement of your charges with the information requested. Any fee that will result in a total charge exceeding $200 must receive prior approval from PSRS. Please contact our office before processing this request.

SECTION A – MEMBER INFORMATION

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

Member ID	Last Four Digits of Member's Social Security Number	Account ID	Member's Date of Birth

Mailing Address

City	State	ZIP	Telephone ( )

Email Address

SECTION B – PATIENT AUTHORIZATION

I hereby authorize the physician/facility below to release to the Public School Retirement System of Missouri (PSRS) any and all information acquired as a result of examination or treatment of me to be used for the purpose of determining my eligibility for disability retirement. I further waive all provisions of law forbidding release of information by an attending or examining physician.

Physician/Facility Name

Mailing Address

City	State	ZIP

Time Limit and Right to Revoke Authorization: Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the above named physician/facility. Unless revoked, this authorization will expire on the following date or event, or one year from date of signature, unless otherwise specified.	Date or Event of Expiration:

SECTION C – INFORMATION TO BE RELEASED

Information to be released covering the periods of health care for the dates below.

From (date):	To (date):

Please check type of information to be released:

☐ Complete Health Record	☐ Lab Test Results	☐ Operative Report(s)	☐ History and Physical
☐ Consultation Report(s)	☐ X-Ray Report(s)	☐ Progress Note(s)	☐ ER Report(s)
☐ Discharge Summary	☐ Medication(s)	☐ Pathology Report(s)	☐ Treatment(s)

Other (Specify)

Drug and/or Alcohol Abuse and/or Psychiatric Release: I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check one:** ☐ Yes ☐ No

HIV/AIDS Records Release: I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. **Check one:** ☐ Yes ☐ No

SECTION D – MEMBER SIGNATURE

Re-Disclosure: I understand that if I authorize release of my Protected Health Information to a person or organization that is not subject to federal law governing privacy, and that person or organization re-discloses my Protected Health Information, my Protected Health Information may no longer be protected by federal privacy laws.

Signature of Member (REQUIRED)	Date
X	

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TAX WITHHOLDING AUTHORIZATION FOR MONTHLY BENEFITS

Instructions:

- Please review page 2 before completing this form.
- Return completed authorization to the Public School Retirement System of Missouri (PSRS) at the address above.
- Please keep a copy of this form for your records.

SECTION A – BENEFIT RECIPIENT INFORMATION

First Name	Middle Name	Last Name

Member ID (or Last Four Digits of Your Social Security Number)	Account ID	Telephone ( )

Mailing Address	City	State	ZIP

Email Address

SECTION B – FEDERAL TAX WITHHOLDING

Instructions: Complete only one choice below.

IMPORTANT NOTE: The IRS does not allow the withholding of federal taxes in a specified dollar amount only. However, you can withhold an amount based on the number of allowances you choose and federal tax tables, with an additional specified dollar amount withheld (see Choice 2 below). Please contact your tax advisor or visit **www.irs.gov** for more information. Worksheets to assist you when determining the number of allowances can be found on IRS form W-4P.

☐ **Choice 1: No Federal Tax Withholding**
I do **not** want PSRS to deduct federal income tax from my monthly benefits. This choice does **not** relieve me of any tax liability.

☐ **Choice 2: Federal Tax Withholding Based on Marital Status and Number of Allowances**
I want PSRS to deduct from my monthly benefits the amount required, if any, based on IRS tables using the marital status and allowances I have chosen below.

Marital Status: ☐ Married ☐ Single ☐ Married but withhold at single rate

Number of Allowances: _____ (will use zero if incomplete)

Additional Withholding: Under Choice 2, you can choose to have an additional specified amount withheld each month.
In addition to the amount based on the allowances specified above, I want an extra $_____ withheld from each benefit.

SECTION C – MISSOURI RESIDENTS ONLY – MISSOURI TAX WITHHOLDING

Instructions: Complete only one choice below. NOTE: PSRS cannot withhold income taxes for states other than Missouri. For help determining a withholding amount, visit the Missouri Department of Revenue's website, **https://mytax.mo.gov/rptp/portal/home/withholding-calculator**

☐ **Choice 1: No Missouri Tax Withholding**
I do **not** want PSRS to deduct Missouri income tax from my monthly benefits. This choice does **not** relieve me of any tax liability.

☐ **Choice 2: Missouri Tax Withholding in a Specified Amount**
I want PSRS to withhold a specified even dollar amount of $_____ from each monthly benefit.
(The minimum withholding amount is $10.)

SECTION D – BENEFIT RECIPIENT AUTHORIZATION

Digital Signatures Not Accepted – Original (Written) Signature Required	Date
X	

Print Clear

TAX WITHHOLDING AUTHORIZATION FOR MONTHLY BENEFITS

Use this ***Tax Withholding Authorization*** form to authorize the Public School Retirement System of Missouri (PSRS) to withhold federal and Missouri income tax from the taxable portion of your monthly benefits. Please note the following:

- Once you file an authorization, it remains in effect until you file another. A withholding change, start or stop can be made on this authorization form or on federal form W-4P and Missouri form W-4P.

- If the taxable portion of your monthly benefit is **less** than the withholding level for a married person claiming three allowances, tax will not be withheld unless you instruct us to do so. If the taxable portion of your monthly benefit is **more** than the withholding level for a married person claiming three allowances and you do not return a completed authorization, the retirement office is required by federal law to withhold at the rate set for a married taxpayer with three allowances.

- If your authorization is received by the 15th of the month, it will be processed for the payment issued on the last working day of that month. If you desire the change to be made at a later date, please indicate the effective date on the bottom of this form.

PSRS is not attempting to advise you that you should or should not have income tax withheld from your benefits. That decision is yours. We are furnishing this tax information merely to meet the requirements of the law. If tax withholding or your estimated tax payments are not sufficient to meet your tax liability, you may be subject to penalties and interest charges in addition to your tax obligation.

Individuals receiving Social Security benefits, Social Security disability benefits or benefits from a public retirement system (such as PSRS) are allowed to deduct some or all of those benefits from their adjusted gross income for Missouri tax purposes. Individuals must have an adjusted gross income of $85,000 or less if single or $100,000 or less if married and filing jointly to qualify for the maximum deduction.

Social Security recipients can deduct their entire benefit, per adjusted gross income level restrictions. Individuals receiving a retirement benefit from a public plan, including PSRS, are allowed to deduct up to the maximum Social Security benefit available for that tax year. The maximum Social Security benefit available is adjusted for inflation every year at the federal level. Those individuals who receive both Social Security benefits and PSRS benefits will deduct their entire Social Security benefit first, then as much of their PSRS benefit until they reach the maximum deduction.

Visit the Missouri Department of Revenue website **http://www.dor.mo.gov** or call **(573) 751-3505** for more information. We cannot withhold Missouri income tax unless you reside within the state of Missouri and send to PSRS either a MO W-4P or a PSRS form authorizing such withholding.

If you have any questions about completing the ***Tax Withholding Authorization*** form, we recommend speaking with a PSRS representative by calling **(800) 392-6848**. However, any questions about taxes or your tax liability should be directed to the IRS, the Missouri Department of Revenue, or your tax consultant.

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DIRECT DEPOSIT AUTHORIZATION

FOR ELECTRONIC FUNDS TRANSFER OF MONTHLY BENEFIT PAYMENTS

Instructions: Use this form to authorize direct deposit of your Public School Retirement System of Missouri (PSRS) benefits to a financial institution. Missouri law requires all PSRS benefit payments to be electronically transferred to your bank or financial institution.

- Attach a voided check for a checking account or a voided deposit slip for a savings account. If the account is a revocable trust account, please attach a copy of the trust document.
- Return the completed form to PSRS at the address above.
- Authorization forms received by the 15th of the month are processed in the month received. You will receive written confirmation when your authorization is processed.

If you have more than one membership with the Public School and Education Employee Retirement Systems of Missouri (PSRS/PEERS), you must submit a separate *Direct Deposit Authorization Form* for each membership. This authorization applies only to benefits you are eligible to receive or are already receiving from your PSRS membership with the Account ID number shown in Section A below. If you have questions, please call our office.

SECTION A – BENEFIT RECIPIENT INFORMATION

First Name	Middle Name	Last Name

Member ID (or Last Four Digits of Your Social Security Number)	Account ID	Telephone ( )

Mailing Address	City	State	ZIP

Email Address

SECTION B – BANK/FINANCIAL ACCOUNT INFORMATION

Name(s) Listed on Account

Type of Account (select one)

☐ Checking Account (**attach voided check**)	Routing Number on Account (See page 2)	Account Number
☐ Savings Account (**attach voided deposit slip**)	Routing Number on Account (See page 2)	Account Number

Is the account above a revocable trust account? ☐ Yes ☐ No **If yes, attach a copy of the trust. Irrevocable trusts cannot be accepted.**

SECTION C – BANK/FINANCIAL INSTITUTION INFORMATION

Name of Bank/Financial Institution	Telephone ( )

Mailing Address	City	State	ZIP

SECTION D – BENEFIT RECIPIENT CERTIFICATION AND AUTHORIZATION

I hereby appoint the bank/financial institution designated above as my agent to receive and collect the amount payable to me from PSRS for the purpose of making an electronic funds transfer to my account in that institution. This authorization is not an assignment of my rights to receive such payment. I certify that my name, or the name of my revocable trust is on the account listed, and I have direct access to the funds held in my account in the financial institution. This authorization is to remain in full force and effect until PSRS has received notification from me of its termination or revocation in such time and in such manner as to afford PSRS and the financial institution a reasonable opportunity to act on it. I understand that my authorization cannot be revoked by contacting the financial institution. I also permit the release by the bank or financial institution of my current address, names and current addresses of all persons listed on the account, and names and current addresses of all beneficiaries on the account, including, but not limited to those listed as "payable on death" or "transfer on death" to PSRS.

Digital Signatures Not Accepted – Original (Written) Signature Required	Date
X	

Print Clear

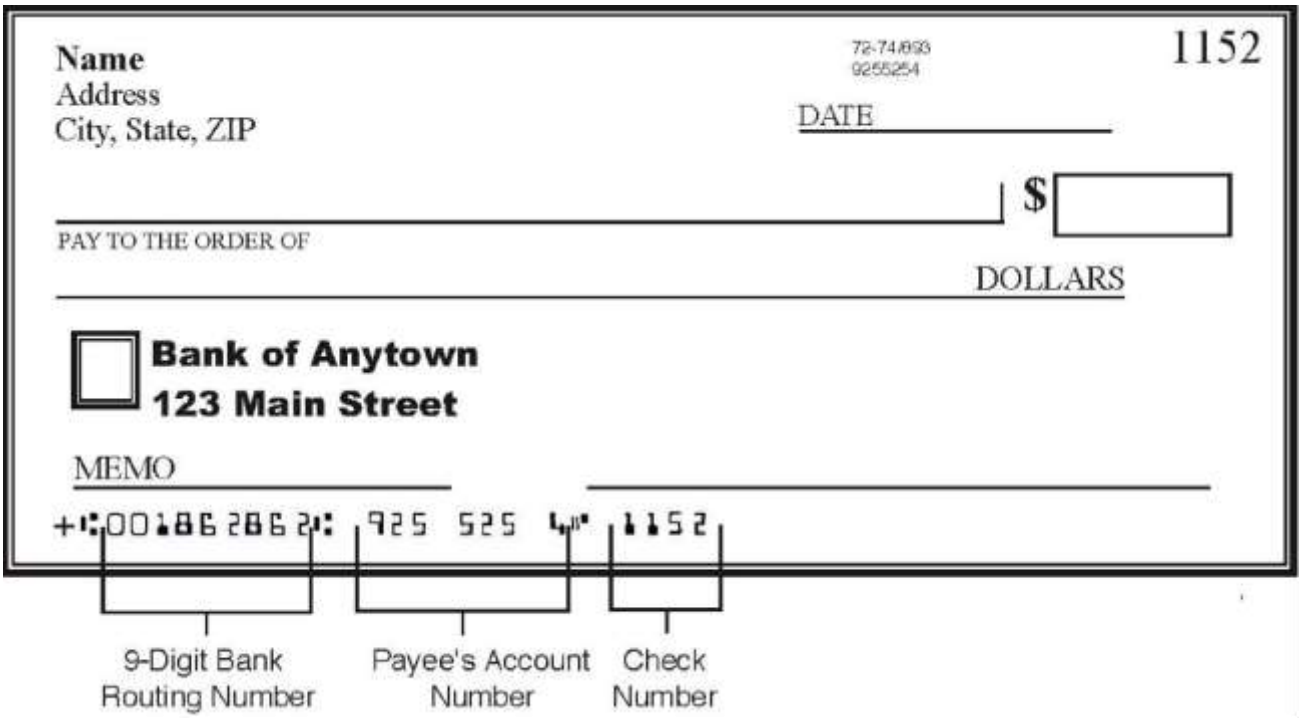
DIRECT DEPOSIT AUTHORIZATION

HOW TO FIND YOUR BANK ROUTING NUMBER AND ACCOUNT NUMBER

***Your request cannot be processed* without confirmation of the routing number of your bank/financial institution and your account number, which are printed on your check.**

The sample check below shows where to locate the required bank information to complete your ***Direct Deposit Authorization*** form.

Sample Check



NOTE: Check styles may vary in the placement of routing and account numbers. Please check with your bank if you need clarification.

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$5,000 DEATH BENEFIT BENEFICIARY DESIGNATION

Please review page 2 before completing this form.

SECTION A – MEMBER INFORMATION

First Name	Middle Name	Last Name

Member ID (or Last Four Digits of Your Social Security Number)	Account ID	Telephone ( )

Mailing Address	City	State	ZIP

Email Address

SECTION B – BENEFICIARY DESIGNATION

I hereby request and authorize the PSRS/PEERS Board of Trustees to pay the $5,000 Death Benefit due at my death to the primary beneficiary listed below. Payments to the First or Second Contingent beneficiaries occur only if the preceding beneficiary is deceased. I reserve the right to change this designation by filing a new *$5,000 Death Benefit 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 C – MEMBER CERTIFICATION

I have reviewed the reverse side of this form and understand that this beneficiary designation applies only to the $5,000 Death Benefit. This designation supersedes and renders void any previous beneficiary designations for this benefit and becomes effective upon receipt in the PSRS office.

Digital Signatures Not Accepted – Original (Written) Signature Required	Date
X	

Print Clear

$5,000 DEATH BENEFIT BENEFICIARY DESIGNATION

This form establishes your beneficiary designation for a lump-sum death benefit of $5,000 that is payable at your death. The beneficiary designation made with this form applies after your effective retirement date.

If the space provided on this form is not sufficient for your desired designation, please include a dated attachment, which bears your original signature. This designation supersedes and renders void all previous designations of beneficiaries to receive the $5,000 Death Benefit.

You may designate an individual(s), a trust if one has been legally established, or any other legal entity(ies) to receive this benefit. If you name multiple primary or contingent beneficiaries, they will share equally unless you indicate otherwise. Any payment to a minor or a person who is legally incompetent will be paid to a legally authorized representative of the beneficiary.

This designation relates only to the $5,000 Death Benefit and does not change the beneficiary whom you may have named under a Joint-and-Survivor or Term-Certain plan, nor does it affect the beneficiary named to receive any balance of unused contributions and interest, if any, remaining in your membership at your death.

This payment is a taxable death benefit distribution.

If you do not have a valid beneficiary designation on file to receive this benefit, payment will be made to your 1) surviving spouse, 2) surviving children in equal shares, 3) surviving parents in equal shares, or 4) estate, in that order of precedence.

PSRS will acknowledge your beneficiary designation. You may also view your beneficiary designation on the PSRS website, **www.psrs-peers.org**.

If you have questions about designating beneficiaries or how to complete this form, we recommend speaking with a PSRS representative by calling **(800) 392-6848**.