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 PSRS
- Must be less 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 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 PSRS.

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** **Download the IRS Form W-4P from www.psrs-peers.org/W4P. Complete it and submit it with the *Missouri Tax Withholding Authorization* form, included in this packet.** 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.**

IMPORTANT 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 PSRS prior to your effective retirement date.

- **Please complete and return both pages of this application to PSRS 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.
- 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
Account ID (or Last Four Digits of Member's Social Security Number)	Member 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
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 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: _____ **1,** _____
(month) (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 PSRS if I am employed in **any capacity** for any employer 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 PSRS-covered employers up to the hourly and/or salary limits that apply, and most work outside of PSRS is unrestricted.

Member Signature (REQUIRED) **X**	Date

SECTION G – 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 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 PSRS.
- I must contact PSRS 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 PSRS.I also certify that the information given herein is true and correct.

Member Signature (REQUIRED) **X**	Date

PSRS/PEERS
PUBLIC SCHOOL & EDUCATION EMPLOYEE
RETIREMENT SYSTEMS OF MISSOURI

PO Box 268
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Email: psrspeers@psrspeers.org
Website: www.psrs-peers.org

Completing IRS Form W-4P
Frequently Asked Questions

Q: Where can I find IRS Form W-4P?
A: You can download IRS Form W-4P at https://www.psrs-peers.org/w4p. We cannot include the form in this online packet because the IRS does not allow us to merge their forms with ours.

Q: When do I need to submit IRS Form W-4P?
A: Submit IRS Form W-4P when:

- You apply for monthly benefits from PSRS/PEERS, or
- You want to change how much federal tax PSRS/PEERS withholds from your monthly benefits.

Q: What happens if I don't submit IRS Form W-4P?
A: It depends on whether you are applying for the first time or already receive benefits:

- If you're applying for monthly benefits for the first time and you don't submit Form W-4P: The IRS requires PSRS/PEERS to withhold federal income tax as if your filing status is single with no adjustments.
- If you already receive monthly benefits: Your current withholding election (or your default rate) stays the same until you submit a new IRS Form W-4P.

Q: Can I choose not to have federal income tax withheld?
A: If you are a U.S. citizen or resident alien and payments will be delivered within the U.S., you may elect no federal withholding. Federal withholding is generally required on payments delivered outside of the U.S. and to nonresident aliens.

Q: How do I know if I should have federal income tax withheld from my monthly benefits?
A: That depends on your personal financial situation. We recommend:

- Reviewing the instructions on Form W-4P,
- Using the IRS Tax Withholding Estimator at www.irs.gov/W4App, and/or
- Consulting a tax professional.

Q: Does Form W-4P apply to lump-sum payments?
A: No. Lump-sum or rollover distributions use Form W-4R, not W-4P.

Q: How do I request Missouri state income tax withholding from my monthly benefits?
A: Missouri withholding is voluntary and requires a separate form. To have Missouri tax withheld from your monthly benefits, submit the PSRS/PEERS ***Missouri Tax Withholding Authorization for Monthly Benefits*** form.

Q: What happens if I don't submit a Missouri withholding form?
A: PSRS/PEERS will not withhold Missouri state income tax unless you submit the Missouri form.

Q: How often can I change my withholding?
A: You can update your federal or Missouri withholding at any time by submitting the appropriate form.

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MISSOURI TAX WITHHOLDING AUTHORIZATION FOR MONTHLY BENEFITS

- **See page 2 for instructions and information about this authorization form.**
- Return completed authorization form 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

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

Mailing Address

City	County	State	ZIP

Telephone ( )	Email Address

SECTION B 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.)**

Effective Date:
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 want the change made at a later date, please indicate the date here:_____.

SECTION C BENEFIT RECIPIENT AUTHORIZATION

Signature **(REQUIRED)** **X**	Date

MISSOURI TAX WITHHOLDING AUTHORIZATION FOR MONTHLY BENEFITS

Use this ***Missouri Tax Withholding Authorization*** form to authorize the Public School Retirement System of Missouri (PSRS) to withhold 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. However, if you move out of state, your Missouri tax withholding will automatically stop. You can start, stop or change withholding using this form or Missouri form W-4P.

- 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 this form.

- We cannot withhold Missouri income tax unless you reside within the state of Missouri and send to PSRS either a Missouri form W-4P or a PSRS form authorizing such withholding.

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.

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

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

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	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	

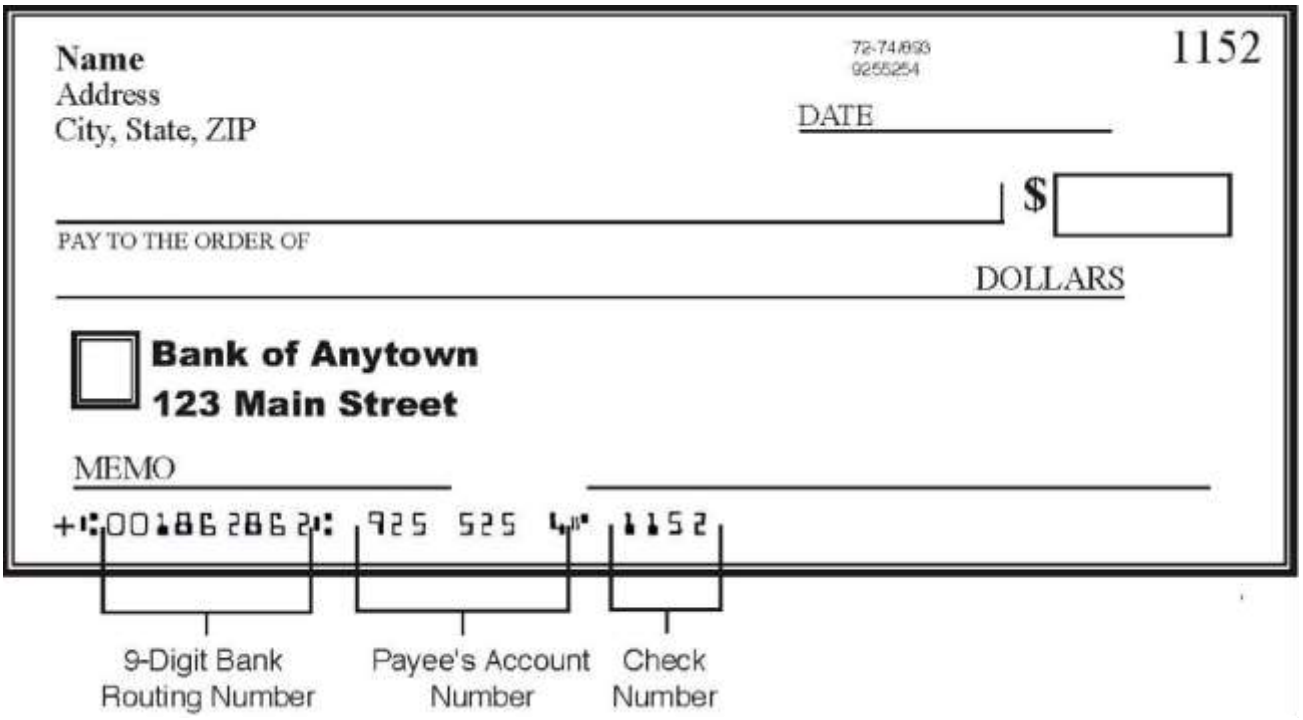
DIRECT DEPOSIT AUTHORIZATION

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

Instructions:

- Review the information on the reverse side before completing this form. Return the completed form to PSRS at the address above.
- Make sure you sign the form.
- If the space provided on this form is not sufficient for your designation, please include a dated attachment with your original signature.
- Keep a copy for your records.

SECTION A MEMBER INFORMATION

First Name	Middle Name	Last Name

Account ID (or Last Four Digits of Your Social Security Number)	Member ID (if known)	Telephone (include area code)

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 by PSRS.

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

$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**.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

SECTION A – MEMBER INFORMATION

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

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

Mailing Address			
City	**County**	**State**	**ZIP**

Telephone ( )	Email Address

SECTION B – HIPAA AUTHORIZATION FOR CARE PROVIDERS AND CONSULTANTS

I hereby authorize the use and disclosure of protected health information (PHI) about me for the purpose of my application for PSRS disability benefits as described below.

- The following specific person/class of person/facility is authorized to disclose PHI about me to PSRS and its Medical Advisor, Managed Medical Review Organization (MMRO): Any health care provider, hospital, medical facility, clinic, laboratory, rehabilitation center, or similar organization.
- The following person, class of persons, or entity may receive disclosure of PHI about me: PSRS, MMRO, any independent medical examiners and consultants retained by PSRS or MMRO.
- The following PHI may be disclosed: All records and other information with respect to any physical or mental condition or treatment of me, including, but not limited to, information regarding AIDS/HIV infection or treatment, communicable diseases, alcohol/substance abuse and treatment, mental health/psychiatric care, and gene-related impairments (including genetic test results).

SECTION C – AUTHORIZATION FOR PSRS AND MMRO TO RELEASE INFORMATION

I authorize PSRS and MMRO to provide PHI and other information on my disability file to any independent medical reviewer/examiner/consultant retained by PSRS or MMRO. I understand that such information may ultimately be used by the PSRS/PEERS Board of Trustees and circuit/appellate court judges in the event of any Board appeal or litigation related to my disability retirement application.

SECTION D – MEMBER SIGNATURE

- Except to the extent that action has already been taken in reliance on this authorization, I understand that I may revoke this authorization by notifying PSRS in writing of my desire to revoke it.
- This authorization expires one year from the date of my signature or upon the final determination of my eligibility for PSRS disability benefits, whichever is later. I authorize the use of a copy (including an electronic copy) or facsimile of this form.
- I understand that if I authorize release of my PHI to a person or organization that is not subject to federal law governing privacy, and that person or organization re-discloses my PHI, my PHI may no longer be protected by federal privacy laws.
- I understand that I have the right to request a copy of this authorization.

I certify that I have read, understand and agree to the above authorizations to release information.

Signature of Member (REQUIRED) **X**	Date

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ATTENDING PHYSICIAN STATEMENT- to be completed by your physician(s)

*Please provide a copy of this statement to all of your treating physicians *

Physician(s) must complete and send this form directly to PSRS with copies of medical and clinical records for the past three years or from the onset of the medical condition, whichever is longer.

It is your responsibility to contact your physicians to ensure all relevant medical records are forwarded to PSRS.

MEMBER INFORMATION		
Name - Last	First Name, MI	Account ID
Date of onset of current medical condition or injury:		
PRESENT CONDITION OF MEMBER		
Chief Complaints:		
Subjective symptoms:		
DIAGNOSIS		
Diagnosis 1:		
Objective Examination Findings 1:		
Diagnostic Test – Dates and Findings:		
Diagnosis 2:		
Objective Examination Findings 2:		
Diagnostic Test – Dates and Findings:		

Restrictions

What are the member's physical limitations and work restrictions?

Please address all below if applicable:	Max*	Not Applicable	Occasional 0 to 2.6 hours/day	Frequent 2.7 to 5.3 hours/day	Constant 5.4 to 8 hours/day
Low Lift (floor to knuckle)	☐	☐	☐	☐	☐
Mid Lift (knuckle to shoulder)	☐	☐	☐	☐	☐
Full Lift (floor to shoulder)	☐	☐	☐	☐	☐
Carrying	☐	☐	☐	☐	☐
Pushing	☐	☐	☐	☐	☐
Walking	N/A	☐	☐	☐	☐
Climbing	N/A	☐	☐	☐	☐
Balance	N/A	☐	☐	☐	☐
Stoop	N/A	☐	☐	☐	☐
Kneeling	N/A	☐	☐	☐	☐

Other Comments:

MEMBER INCAPACITY

Name - Last	First Name, MI	Account ID

To qualify for a disability retirement, the member must meet the legal standard under Missouri law which provides,

Disability, as a basis for retirement, shall render the individual incapable of earning a livelihood in any occupation and shall be of such a nature as to warrant the assumption that it will be permanent.

Based on the standard above, is the member disabled from working any job?

Yes ◯ No ◯

If so, please explain why.

Last date you have seen the claimant:

Do you anticipate improvement that will permit the member to return to employment? Yes ◯ No ◯

If so, please explain.

REQUIRED SIGNATURE

I certify that the information provided is correct to the best of my knowledge.

☐ *I have provided all necessary **medical records** to PSRS/PEERS.*

Physician's printed name	Type of practice/specialty	
Physician's signature	Date Signed	Telephone Number ( )
Address		
City	State	Zip Code