

APPLICATION FOR DISABILITY RETIREMENT

Section 1: Member Information (Please Print)

1. Last Name		2. First Name		3. Middle Name	
4. Social Security Number		5. Personal Email Address		6. Home/Cell Number	
7. Mailing Address			8. City		9. State
					10. Zip Code
11. Date of Birth		12. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Qualified Domestic Partner			
13. Date of Marriage (If applicable)		14. Spouse/Domestic Partner Name (If applicable)			
15. Employer / Agency				16. Proposed Effective Date	

Section 2: Reason for Retirement

For a description of the payment options, see your Summary Plan Description on OCERS' website under the section titled: "Your Retirement Payment Options."

Check the Appropriate Box:

Service Connected Disability Non-Service Connected Disability BOTH

I HAVE CHOSEN TO LIMIT THE SCOPE OF THIS APPLICATION AND UNDERSTAND THAT I MAY LOSE BENEFITS IN THE FUTURE. _____

Initial

Section 3: Benefit Payment Election

BENEFIT PAYMENT OPTIONS ARE IRREVOCABLE AFTER RECEIPT OF YOUR FIRST RETIREMENT PAYMENT

I elect the following benefit payment option: (Choose one of the following payment options)

UNREDUCED BENEFIT PAYMENT

Unmodified Payment

Monthly benefit payable for your lifetime. No continuance of monthly benefit after death unless you have an eligible surviving spouse or children. Surviving spouse or children receive a continuance of your monthly benefit upon your death based on retirement benefit.

REDUCED BENEFIT PAYMENT

Option Payment 1

Reduced monthly benefit payable for your lifetime. Surviving beneficiary receives a lump sum payment equal to accumulated contributions less the sum of annuity portion of benefits already received.

Option Payment 2

Reduced monthly benefit payable for your lifetime. Surviving beneficiary receives a 100% continuance of your monthly benefit upon your death (except in the case of a non-spouse beneficiary who is greater than 10 years younger, whose continuance percentage will be actuarially determined at the time of retirement). **Beneficiary cannot be changed.**

Option Payment 3

Reduced monthly benefit payable for your lifetime. Surviving beneficiary receives a 50% continuance of your monthly benefit upon your death. **Beneficiary cannot be changed.**

Option Payment 4

Any type of benefit payment approved by the Board. **Beneficiary cannot be changed.**

Section 4: Naming Your Beneficiary

1. You may name one person or any number of persons as your primary or alternate beneficiary.
 - a. **Primary Beneficiary:** A primary beneficiary is the person or persons who would receive a benefit from OCERS upon your death.

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- b. **Alternate Beneficiary:** An alternate beneficiary is the person or persons who will receive a benefit from OCERS if you have no living primary beneficiaries on the date of your death.
 - c. If you wish to name more than two persons in either category, attach a separate sheet and be sure to indicate what percentage of the benefit each individual is to receive. Please note that all beneficiary percentage designations must be **whole** numbers (for example 33%, not 33.3%). The total must equal 100 percent. If you do not indicate a percentage, the benefit will be divided into equal parts. On any additional sheets of paper be sure to sign your name and date the piece of paper before attaching it to your form.
2. Please note that your beneficiary designation for retirement benefits is irrevocable under Optional Payments 2, 3 and 4.
 3. **Notice to Married Participants:** If you wish to name a person other than your spouse (or in addition to your spouse) as your primary beneficiary, a Spousal Waiver Form must be properly executed and submitted. This form can be obtained from the Member Services Department.

BENEFIT PAYMENT OPTIONS ARE IRREVOCABLE AFTER RECEIPT OF YOUR FIRST RETIREMENT PAYMENT

Primary beneficiary designation(s) – (percent of Benefit must total 100%)

1. Beneficiary Name	2. Social Security Number	3. Relationship	4. DOB	5. % of Benefit
6. Mailing Address		7. City	8. State	9. Zip Code

Primary beneficiary designation(s) – (percent of Benefit must total 100%)

10. Beneficiary Name	11. Social Security Number	12. Relationship	13. DOB	14. % of Benefit
15. Mailing Address		16. City	17. State	18. Zip Code

Alternate beneficiary designation(s) – (percent of Benefit must total 100%)

19. Beneficiary Name	20. Social Security Number	21. Relationship	22. DOB	23. % of Benefit
24. Mailing Address		25. City	26. State	27. Zip Code

Alternate beneficiary designation(s) – (percent of Benefit must total 100%)

28. Beneficiary Name	29. Social Security Number	30. Relationship	31. DOB	32. % of Benefit
33. Mailing Address		34. City	35. State	36. Zip Code

Section 5. Member Acknowledgement

I hereby affirm that the statements I have made on this Disability Retirement Application are true and correct to the best of my knowledge and belief.

Member Signature

Date