Benefits (an official leave of absence is concidered in service);

- be an active member of the PFRS on the date of the traumatic event (see definition below);
- be considered totally and permanently disabled (you must prove that you are physically or mentally incapacitated from performing your normal or assigned job duties with no possibility for significant improvement) as a direct result of a traumatic event that happened during and as a direct result of carrying out your regular or assigned job duties;
- file an application within five years of the date of the traumatic event;
- be examined by physicians selected by the retirement system at no cost to you. The examination will be scheduled by the Division of Pensions and Benefits; and
- provide any and all accident reports, witness reports, and corroborating evidence on file for any and all accidents for which you are filing.

A **"Traumatic Event"** has been defined by the courts as one in which the worker is involuntarily exposed to a violent level of force or impact which is not brought into motion by the worker.

To be eligible for Accidental Disability retirement benefits, the worker must demonstrate that:

- the injury was not induced by normal work effort;
- the worker met involuntarily with the object that was the source of the harm; and
- the source of the injury was a violent or uncontrollable power.

The following examples would not be considered traumatic events:

- Slip and fall cases, no force or power originates anywhere except from the person falling and the gravitational force on the person was not considered "great";
- A laborer who injured his wrist when a jackhammer twisted in his hand, was not injured as a direct result of a great rush of force or uncontrollable power;
- A member's heart attack, although the result of job stress and tension, was not considered a traumatic event.

If you qualify for an Accidental Disability Retirement benefit, your annual pension will be 2/3 of your annual compensation on which pension contributions were being made at the time of retirement or the date of the traumatic event, whichever provides the higher benefit.

If you are receiving periodic Workers' Compensation benefits, your Accidental Disability retirement benefits will be reduced dollar for dollar by the periodic benefits paid after your retirement date. The retirement benefit is not reduced by any Social Security or private insurance benefits that may be payable.

The Division of Pensions and Benefits reports your Accidental Disability retirement benefit as exempt from federal income tax; your benefits are not subject to New Jersey State income tax until you reach age 65.

If you apply for Accidental Disability retirement and are found by the Board of Trustees to be totally and permanently disabled, but not because of a traumatic event or the event was not the primary cause of your disability, you will be retired on an Ordinary Disability if you have 4 years of New Jersey service in the retirement system. You may also be offered a Service or Special Retirement (this depends on your age and service credit at the time the application was received).

APPLYING FOR DISABILITY RETIREMENT BENEFITS

The *Application for Disability Retirement* can be obtained:

- from our Web site at:
  www.state.nj.us/treasury/pensions
- by writing to the Division of Pensions and Benefits, PO Box 295,Trenton, NJ 08625-0295;
- by contacting the Office of Client Services by telephone at (609) 292-7524; or
- by e-mail request to:
  pensions.nj@treas.state.nj.us

The *Application for Disability Retirement* includes forms for your physicians to complete and a release for any hospital records related to your disability. Applicants for disability retirement must submit all supporting hospital and physician records. At least two forms of medical documentation are required; i.e. a statement from two treating physicians or one statement and records from a hospital stay related to the

Workers' Compensation

Public Employees' Retirement System • Teachers' Pension and Annuity Fund
Police and Firemen's Retirement System • State Police Retirement System

The receipt of Workers' Compensation is designed to compensate employees who suffer work-related injuries or illnesses. Workers' Compensation payments may be paid in lump sums or in weekly payments over a period of time (periodic payments). Workers' Compensation benefits paid in lump sums or made for medical treatments and expenses do not affect pensions. Therefore, this publication deals only with payment of temporary and permanent disability benefits paid as a periodic benefit through Workers' Compensation.

WORKERS' COMPENSATION AWARDS "WITH PAY"

If an employer keeps an employee on regular payroll and/or the insurance company pays the employer (not the member) the equivalent of the member's full salary, then all pension deductions should be taken from that payment, including loan and (purchase) arrears deductions. It is as though the member is still active in all respects for pension purposes. Full contributions/repayments would be remitted monthly, and full service credit, salary, contributions, and other deductions would be reported quarterly on the Report of Contributions (ROC).

If a periodic Workers' Compensation award "with pay" is for only a percentage of the member's regular salary, the member still contributes the normal amount of pension deductions and is reported at the full base salary in effect prior to the leave on the ROC.

Employer Augmented Workers' Compensation Awards

Some employers augment Workers' Compensation awards that are for less than full base salaries. When an employer augments or compensates for the remaining portion of the member's full salary, the member is treated as "with pay" and the member's full contributions and regular deductions are withheld from the employer's salary payment. The member is also reported for full salary and deductions on the ROC.

For example: an insurance company pays a Workers' Compensation award of 70 percent of base salary directly to the member. The employer elects to augment the award amount by the remaining 30 percent of base salary. The employer would deduct pension contributions and repayments (loans, etc.) for 100 percent of salary from the 30 percent check.

WORKERS' COMPENSATION AWARDS "WITHOUT PAY"

If the only payment the employee is receiving is a check directly from the insurance company, this is considered by the Division of Pensions and Benefits to be Workers' Compensation "without pay."

Normally, no pension credit can be given for periods of time when an employer reports no salary or pension contributions for a member. However, if a member is receiving Workers' Compensation payments, the member's employer may be responsible for payment of the member's pension contributions even though the member is not collecting salary. If required, the contribution is based on the salary a member was receiving before the Workers' Compensation payments began. This enables the member to receive credit in the retirement system for that period of time.

The Division of Pensions and Benefits previously treated temporary and permanent disability benefits paid as periodic benefits through Workers' Compensation differently. The New Jersey Supreme Court decision, James v. Board of Trustees of the Public Employees' Retirement System, 164 NJ 396, 753 A. 2d 1061 (2000) eliminated the distinction between temporary and permanent Workers' Compensation awards for pension purposes for those receiving Workers' Compensation **without pay**. The court held that an employee who receives periodic Workers' Compensation benefits must be retained on payroll and have pension contributions made by the employer. Employers are not responsible for arrears payments (usually purchases), pension loan payments, or back deductions. Once the periodic benefits for Workers'

Compensation cease, so does the employer's liability for pension contributions.

The court in James also recognized valid terminations from employment as a means of terminating the employer's requirement to pay pension contributions. Therefore, the employer's obligation to make pension contributions for members receiving Workers' Compensation ceases when:

1. The employee voluntarily files for a retirement allowance that is subsequently approved;
2. The employer files an involuntary disability retirement application for the employee that is subsequently approved;
3. The employee voluntarily resigns from employment for reasons other than the inability to perform the job's functions due to the incident that was the basis for the Workers' Compensation claim; or
4. The employee is terminated by the employer for reasons unrelated to a Workers' Compensation award.

When the Division receives notification of a Workers' Compensation award, and the employer has not been making or forwarding employee contributions, the Division will bill the employer for those contributions. If an employer has been making payments of employee pension contributions and ceases to do so due to the reasons listed in items 3 or 4 (above), the employer must notify the Division in writing of the reasons for the cessation of payments.

NONCONTRIBUTORY GROUP LIFE INSURANCE

Noncontributory group life insurance remains in effect while the employer is making pension contributions for the member. During the interval between the time the member is without pay and the actual receipt of the Workers' Compensation award, the employer should place the member on an official leave of absence for personal illness.

CONTRIBUTORY GROUP LIFE INSURANCE
(PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS) ONLY)

While a member of the PERS is receiving Workers' Compensation, the employer is not required to pay contributory group life insurance premiums. In order for a member to continue the contributory portion of group life insurance, the member must remit premiums in advance. Premiums may either be remitted to the Division directly, or the employer may permit the member to pay the premium through the employer.

Direct remittance to the Division requires the use of a *Contributory Group Life Insurance Remittance* card. This card is available from public employers, the Division, or it may be downloaded over the Internet at: *www.state.nj.us/treasury/pensions* Remittance should be done immediately upon leaving the employer's payroll. If a member does not make these optional premium payments, contributory group life insurance is suspended until the member returns to the employer's regular payroll.

If you have any questions on the continuation of contributory group life insurance, please contact your employer. You may also contact the Division of Pensions and Benefits, Office of Client Services at (609) 292-7524.

CONTRIBUTORY GROUP LIFE INSURANCE
(TEACHERS' PENSION AND ANNUITY FUND (TPAF) ONLY)

N.J.S.A. 18A:66-53j provides that while a member of the TPAF is receiving Workers' Compensation, no contributions by the member are required for continuation of the contributory group life insurance benefit.

THE STATE HEALTH BENEFITS PROGRAM AND WORKERS' COMPENSATION

When an employee has a Workers' Compensation award pending, or is receiving an award of periodic benefits under Workers' Compensation or the Second Injury Fund, the employee is considered active in all respects for State Health Benefits Program coverage. Health benefits coverage will continue in force for the employee and all eligible dependents covered under the employee's coverage level selection. If the employee shares in the cost of health benefit premiums, the employee receiving Workers' Compensation "without pay" must pay the employer in advance for his or her share of the premiums. If the Workers' Compensation award is "with pay", the premium share may continue to be

deducted from the employee's paycheck. When an employee ceases being an employee, for any of the four valid termination reasons stated in the section on Workers' Compensation "Without Pay", the health benefits coverage as an employee shall end. The member may then be eligible for coverage continuation under COBRA or possibly as a retiree.

RETIREMENT AND WORKERS' COMPENSATION

Ordinary and Accidental Disability retirement allowances are subject to reductions.

If you are approved for Ordinary Disability retirement benefits and receive a Workers' Compensation award, your Workers' Compensation award may be reduced by the amount of your Ordinary Disability retirement benefit. If you have any questions concerning this issue, please contact your attorney or union representative.

In the case of Accidental Disability retirement, the retirement benefit is reduced on a dollar-for-dollar basis. The following are examples of when a Workers' Compensation award would reduce a retiree's Disability Retirement allowance:

- If the retiree receives a periodic payment award, the weekly dollar amount of the award is converted to a monthly dollar amount, which reduces the pension portion of an Accidental Disability Retirement allowance dollar-for-dollar for as long as the retiree receives the award. The reduction is applied only to Workers' Compensation benefits payable from the retiree's retirement date or later, and does not include such payments before the retirement date. Any assessments, such as attorney fees or court costs charged to the retiree are not subject to the reduction.
- If a retiree receives a Second Injury Fund award, this amount will also be subject to the same dollar-for-dollar offset.

A retiree's Disability Retirement allowance is not reduced by monies received under the award for medical coverage or by a "Section 20" lump-sum award (not the same as a lump-sum payment).

A retiree's Cost-of-Living Allowance (COLA) is also not affected by reductions in the pension portion of the retiree's retirement benefit. The COLA continues to be based upon the retiree's full pension benefit amount regardless of the Workers' Compensation offset.

NOTIFYING THE DIVISION

Either the member or the member's employer must notify the Division of Pensions and Benefits that a Workers' Compensation claim is pending. Once a judge has reviewed the claim and a Workers' Compensation award has been granted, a copy of the award must be sent to the Division of Pensions and Benefits.

Questions regarding the impact of Workers' Compensation on pension benefits may be directed to the Division of Pensions and Benefits, Office of Client Services at (609) 292-7524. General questions regarding Workers' Compensation should be addressed to the Human Resources office of the member's employer.

This fact sheet has been produced and distributed by:
New Jersey Division of Pensions and Benefits • PO Box 295 • Trenton, New Jersey 08625-0295
(609) 292-7524 • TDD for the hearing impaired (609) 292-7718
URL: http://www.state.nj.us/treasury/pensions • E-mail: pensions.nj@treas.state.nj.us

BD-0108-0405

A PUBLICATION OF THE NEW JERSEY DIVISION OF PENSIONS AND BENEFITS

Taxation of Retirement Benefits

All Funds

HOW ARE MY PENSION BENEFITS TAXED FOR FEDERAL PURPOSES?

Pension benefits (except for Accidental Disability and Accidental Death benefits) are subject to federal income tax; however, if you paid tax on any of your contributions to the pension plan, that portion of your monthly benefits representing a return of your previously-taxed contributions is not taxable.

Contributions made to the pension plan prior to January 1, 1987 were already taxed as were any purchases of optional pension membership credit made before 2002. After January 1, 2002 some purchases may have been made with previously-taxed money. Therefore, if you began contributing to the pension plan prior to January 1, 1987, or if you purchased pension membership since then, all or a portion of your total contributions may have been previously subject to federal tax.

The rate at which you can recover your previously-taxed contributions is determined in part by your retirement date.

If you retired before August 1, 1986 — you were able to fully recover your contributions before having to pay tax on your benefits. Once you recovered your contributions, your benefits became fully taxable. *The exception is if you did not fully recover your contributions within the first three years of retirement. In that case, you had to recover your contributions under the IRS expected return rule explained below.*

If you retired on or after August 1, 1986 — you must recover your contributions under the expected return rule. Under this rule, you recover your contributions evenly over your expected lifetime or the combined lifetime of you and your pension beneficiary. This means that only a small portion of each monthly benefit is considered a return of your previously-taxed contributions and is tax-free.

CALCULATING THE NON-TAXABLE AMOUNT

If you retired after July 1, 1986 and before November 1, 1996 — your monthly nontaxable amount is determined using life expectancy tables found in IRS Publication 939.

If you retired on or after November 1, 1996 —

the following tables are used to determine your monthly nontaxable amount:

TABLE A

Benefits Payable To Retiree Only*

Age of Retiree (at retirement)	Number of Payments
55 or less	360
56-60	310
61-65	260
66-70	210
71 or more	160

**For those retired on or after November 1, 1996 and before December 1, 1997, Table A is used even if benefits are payable to the retiree and the retiree's survivor.*

TABLE B

Benefits Payable To Retiree and Beneficiary

Combined Age of Retiree (at retirement) & Beneficiary	Number of Payments
110 or less	410
111-120	360
121-130	310
131-140	260
141 or more	210

The following examples illustrate how the monthly nontaxable amount is computed using Tables A and B:

Example 1 — *A PERS member whose previously-taxed contributions equaled $12,000 retires at age **62** and chooses to receive the maximum allowance (designating no monthly pension to a surviving beneficiary). **Table A** is used because benefits are payable to the retiree **only**. The $12,000 is divided by 260 which produces a monthly tax-free amount of $46.15. The balance of the monthly pension is subject to federal income tax.*

Example 2 — *A TPAF member whose previously-taxed contributions equaled $15,000 retires at age 60 and chooses to receive benefits under Option 2 (designating the same monthly pension to the surviving beneficiary). **Table B** is used because benefits are payable to the retiree **and** the retiree's beneficiary. The designated beneficiary is the same age as the retiree. The $15,000 is divided by 360 which produces a monthly tax-free amount of $41.67. The balance of the monthly pension is subject to federal income tax.*

HOW LONG WILL THE NON-TAXABLE PORTION CONTINUE?

For those who retired after December 31, 1986 the monthly nontaxable amount remains in effect until all of your previously-taxed contributions are fully recovered. At that point your benefits become fully taxable.

For those who retired before December 31, 1986 the monthly nontaxable amount is effective for as long as you or your survivor receive benefits.

If benefits cease before your previously-taxed contributions are fully recovered, the remaining balance can be claimed as a deduction on the income tax return of the last recipient, provided you retired on or after July 1, 1986. If you retired before July 1, 1986, no deduction is allowed for unrecovered contributions.

WITHHOLDING FEDERAL INCOME TAX FROM YOUR PENSION CHECK

Each new retiree will automatically receive a federal withholding tax form (W4-P) near the date of retirement. The Division of Pensions and Benefits is required by federal law to **automatically withhold federal income tax** from your pension check, based on a status of married with three allowances if you do not complete a W4-P. The W4-P allows you to elect no withholding or, if you want withholding, to inform us of your tax filing status so that we can withhold the proper amount.

WITHHOLDING NJ STATE INCOME TAX FROM YOUR PENSION CHECK

If you live in New Jersey you will automatically receive a New Jersey State withholding tax form (NJ W4-P) near the date of retirement. Most retirees will not be subject to New Jersey income tax until they recover in pension checks the amount of the contributions which they made to the pension plan while working. If you will not recover your total contributions within three years of retirement, refer to your NJ Gross Income Tax Return Form 1040 booklet to determine how your pension is taxed.

If you are at least 62 or considered disabled by Social Security, you may exclude the following amounts of retirement income from New Jersey income tax for the tax year indicated below:

Tax Year	Married Filing Jointly	Single	Married Filing Separately
2000	$12,500	$9,375	$6,250
2001	$15,000	$11,250	$7,500
2002	$17,500	$13,125	$8,750
2003 and beyond	$20,000	$15,000	$10,000

Unlike federal income tax, **withholding for New Jersey income tax is completely voluntary.** No New Jersey income tax will be withheld unless you authorize it by completing a NJ W4-P. The amount withheld must be at least $10.00 per month and in even dollar amounts (no cents). If you need help deciding whether to have this withheld or how much to have withheld, you can contact the New Jersey Division of Taxation at 1-800-323-4400.

If you live outside New Jersey, you are not required to pay New Jersey income tax on the pension you receive from the retirement system. The Division of Pensions and Benefits does not withhold income tax

for other states. Check with your home state's tax office to determine if your pension is taxable in your state of residence.

CHANGING YOUR WITHHOLDING AMOUNT

If you wish to change your withholding **you must submit a new form** which you can obtain by calling the Division of Pensions and Benefits - Benefits Information Library (BIL) 24 hours a day, seven days a week, at (609) 777-1931 (if you have a touch-tone telephone). When your call is answered, press 122 on the key pad of your telephone. At the end of the message you can leave your name, address, and Social Security number, and a federal (or State) withholding form will be sent to you. If you are already having **more than the minimum** federal tax withheld, you should contact the Division of Pensions and Benefits at (609) 292-7524 for assistance in completing the form.

QUESTIONS COMMONLY ASKED AFTER RETIREMENT

Will I receive a statement of pension income for tax purposes?

Yes. Retirees receive Form 1099-R at the end of January each year, covering the previous tax year. This shows the gross retirement allowance; how much is subject to federal income tax; and the amounts, if any, that were withheld for federal and New Jersey income tax.

Am I taxed on the reimbursement of Medicare premiums?

No. Some State employees and all employees of boards of education or county colleges who retired with 25 or more years of service, or on a disability retirement, who are enrolled in the State Health Benefits Program are reimbursed in their pension checks for the Medicare Part B premiums they pay to Social Security. If you receive this Medicare reimbursement, the gross amount of your pension checks will be greater than the gross amount shown on your 1099-R because the Medicare reimbursement is not taxable. The Medicare premium reimbursement is subtracted from your total gross income to arrive at the gross pension reported to the IRS.

Why doesn't my gross allowance equal 12 times the amount of my December 1 check?

When you receive a cost-of-living increase, your pension is changed each year with the February 1 check. Therefore, the gross allowance for your January 1 check is less than your next 11 checks.

Is my disability pension taxable?

If you are receiving a disability pension, your benefits are not subject to New Jersey income tax until you reach age 65.

If you are receiving an *Accidental* Disability pension, — or if you are a survivor receiving Accidental Disability or Accidental Death benefits — the Division of Pensions and Benefits reports your benefit as exempt from federal income tax.

Ordinary Disability pensions are subject to federal tax to the same extent as other pensions. Any questions should be referred to the IRS at the number listed below.

**THE DIVISION OF PENSIONS AND BENEFITS CANNOT GIVE TAX ADVICE.
CONSULT THE IRS (1-800-TAX-1040), OR THE NJ DIVISION OF TAXATION (1-800-323-4400 in NJ),
OR YOUR TAX ADVISOR FOR ASSISTANCE.**

This fact sheet has been produced and distributed by:
New Jersey Division of Pensions and Benefits • PO Box 295 • Trenton, New Jersey 08625-0295
(609) 292-7524 • TDD for the hearing impaired (609) 292-7718
URL: http://www.state.nj.us/treasury/pensions • E-mail: pensions.nj@treas.state.nj.us

BD-0108-0405

POLICE AND FIREMEN'S RETIREMENT SYSTEM
NEW JERSEY DIVISION OF PENSIONS AND BENEFITS

APPLICATION FOR DISABILITY RETIREMENT

PLEASE READ THESE INSTRUCTIONS AND FACT SHEET #16 CAREFULLY BEFORE COMPLETING THIS APPLICATION.

PLEASE DETACH THE APPLICATION FROM THE BOOKLET BEFORE MAILING.

When to File — All retirements are effective on the first of the month. File this application with the Division of Pensions and Benefits before your retirement date or you will lose benefits. Three to five months advance filing is recommended. You must terminate employment before your retirement date. Mail your completed application to the New Jersey Division of Pensions and Benefits, Disability Review Unit, PO Box 297, Trenton, NJ 08625-0297.

INSTRUCTIONS

Please print — black ink preferred — or type.

PART ONE: MEMBER INFORMATION

ITEM 1: MEMBERSHIP NUMBER — Enter your pension system membership number.

ITEM 2: SOCIAL SECURITY NUMBER — Enter your Social Security number.

ITEM 3: DATE OF BIRTH — Insert the month, day, and year of your birth. You should submit a copy of your birth or baptismal certificate if you have not already done so.

ITEM 4: NAME — Insert your full name. If you are married, use your given name, not, for example, "Mrs. John Smith."

ITEM 5: ADDRESS — Enter your present mailing address. Report any change of address before you begin receiving a pension to the Retirement Bureau at the address shown above. Provide your Social Security number and retirement date in the letter. Or, you may change your address over the Internet by using our online change of address form for pending retirees at: *www.state.nj.us/treasury/pensions*

ITEM 6 AND ITEM 7: TELEPHONE NUMBERS — Enter your home and cell telephone numbers. Include your area code.

ITEM 8: HOME E-MAIL ADDRESS — Indicate your home e-mail address, if you have one.

PART TWO: DISABILITY RETIREMENT INFORMATION

ITEM 9: RETIREMENT DATE — Insert the date you wish to retire. The earliest retirement date available to you is the first of next month. Your application must be received by the Division of Pensions and Benefits prior to your retirement date.

ITEM 10: TYPE OF DISABILITY RETIREMENT — Mark the type of retirement for which you are applying. See Fact Sheet #16 for an explanation of each type. If you are requesting an Accidental Disability reirement, enter the date(s) of the accident(s) which caused the disability.

ITEM 11: WORKERS' COMPENSATION — Indicate if a Workers' Compensation claim has been filed.

ITEM 12: APPLICANT'S SUPPORTING STATEMENT — State in layman's terms why you are no longer capable of performing your job. Be as specific as possible. You may use additional pages, if necessary, and these pages must have your signature. Supporting medical information must be submitted prior to your application being approved.

ITEM 13: DATE AND DESCRIPTION OF ACCIDENT — **Complete this item only if you are applying for an Accidental Disability retirement.** Briefly describe what happened. List any witnesses to the accident and attach a copy of any accident reports that were filed.

ITEM 14: PURCHASE INFORMATION — Indicate as to whether or not you have applied for a recent purchase of service credit.

PART THREE: MARITAL STATUS AND CHILDREN

ITEM 15: MARITAL STATUS — Check the appropriate box to indicate your current marital status.

ITEM 16: NAME OF SPOUSE OR DOMESTIC PARTNER — If you are currently married or have entered into a domestic partnership, insert your spouse or eligible domestic partner's full name.

Note: A domestic partner is defined for pension purposes under Chapter 246, P.L. 2003, as a person of the same sex with whom you have entered into a domestic partnership and received a *Certificate of Domestic Partnership* from the State of New Jersey (or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships). If you are naming a domestic partner as a beneficiary, a photocopy of your *Certificate of Domestic Partnership* is required by the Division of Pensions and Benefits along with your *Application for Disability Retirement*

ITEM 17: SPOUSE OR DOMESTIC PARTNER'S SSN — Enter your spouse or domestic partner's Social Security number.

ITEM 18: SPOUSE OR DOMESTIC PARTNER'S ADDRESS — Complete this item only if your spouse's or domestic partner's mailing address is different than yours.

ITEM 19: CHILDREN — List all unmarried child(ren) under the age of 18 (or older if still in high school), or of any age if disabled because of mental or physical incapacity and incapable of substantial gainful employment because of the impairment. This incapacity must last, or be expected to last, for a continuous period of not less than 12 months as determined by the Medical Review Board. Indicate the name, gender, and date of birth of each child. If you need to list more than three children, do so on a separate sheet of paper to be attached to this application. Be sure to list the same information as requested for your group life insurance beneficiaries. Additional sheets must be signed.

PART FOUR: DESIGNATION OF GROUP LIFE INSURANCE BENEFICIARIES

You may name any person or persons as well as an institution, charity, your estate, etc., as a beneficiary for your group life insurance. If you designate an institution or charity, you must also include the institution's or charity's date of incorporation. You may also name multiple beneficiaries. The beneficiary you make on your retirement application designation is effective when your *Application for Disability Retirement* is filed with the Division of Pensions and Benefits and supercedes any previous designation(s).

You should name both a Primary Beneficiary(ies) and a Contingent Beneficiary(ies) for this benefit. If you find it necessary to use additional sheets to complete this section, the attachments must also be signed.

Primary Beneficiary(ies) — List the full name, address, date of birth, and relationship to you of the individual(s)/entity(ies) you want to receive your life insurance proceeds. If you name more than one Primary Beneficiary, the "lump sum" insurance proceeds will be divided equally among those listed. If you do not wish to divide the proceeds equally, please contact the Division of Pensions and Benefits for assistance.

Contingent Beneficiary(ies) — List the full name, address, date of birth, and relationship to you of the individual(s)/entity(ies) you want to receive your life insurance proceeds should your primary beneficiaries not be living at the time of your death. If you name more than one Contingent Beneficiary, the "lump sum" insurance proceeds will be divided equally among those listed. If you do not wish to divide the proceeds equally, please contact the Division of Pensions and Benefits for assistance.

MEMBER'S SIGNATURE AND DATE — Sign and date the application. Your application cannot be processed without your signature.

MEDICAL EXAMINATION FORM INSTRUCTIONS

The Division of Pensions and Benefits needs at least two pieces of medical evidence to determine your eligibility. We require *Medical Examination by Treating Physician* forms from at least two doctors who treated you for your disability or from one doctor if a separate record of treatment for the disability will be sent by a

hospital. Complete Part One of the *Medical Examination by Treating Physician* form and give it to your doctor(s) to complete the rest. It is your responsibility to ensure your doctors complete and forward the forms to the Division of Pensions and Benefits.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION FORM INSTRUCTIONS

This form is required if your disability included any hospitalization. Complete the form and present it to the Records Section of the hospital. You will be responsible for any costs associated with obtaining hospital records required to support your application. If you were not hospitalized for the disability, check the box indicated on the form and return it to the Division of Pensions and Benefits with your retirement application.

AUTHORIZATION FOR DIRECT DEPOSIT

Included in this packet is a form for initiating the direct deposit of your retirement checks. Please complete the *Authorization for Direct Deposit of Benefit Payment* form and send it to the Division of Pensions and Benefits along with your retirement application.

Signing up for direct deposit is a risk-free opportunity to have your retirement benefits available to you the first of every month. **Having your retirement check directly deposited into your checking or savings account eliminates the possibility of a check being lost or stolen. It normally takes 3-4 weeks to have a lost or stolen retirement check replaced.** It also makes it unnecessary for you to go to your bank during periods of inclement weather.

Upon verification of your account information with your bank, your retirement check will be directly deposited in your checking or savings account and you will receive a *Statement of Allowances and Deductions* in the mail. Thereafter, you will receive a *Statement of Allowances and Deductions* each December that summarizes your allowance and deduction information for the year. You will also receive the statement anytime there is a change to your financial information, bank information, or your address. Otherwise, monthly statements are not sent, however, your monthly allowance and deduction information is always available 24 hours a day, 7 days a week by calling the Division's Automated Information System at (609) 777-1777.

EMPLOYER CERTIFICATION

It is important that you notify your employer of your retirement plans since your employer must complete the *Employer Certification for Disability Retirement* included in this application package. Your retirement cannot be processed until the Division of Pensions and Benefits receives this certification.

CHANGE OF DISABILITY RETIREMENT

If, after you submit your application, you wish to change your retirement date or cancel the retirement process, you will need to complete the *Change of Disability Retirement* form. If you are changing your retirement date please submit the form to your employer, so they can complete the salary certification on the back of the form; you or your employer should then forward the form to the Division. Please note that a change of your retirement date must be submitted prior to the effective date of your original retirement date.

If you are cancelling your retirement you may send the form directly to the Division. Please note that once your disability retirement is approved by the Board of Trustees, you cannot cancel your retirement, and your application cannot be withdrawn, cancelled, or amended. A member cannot change the date of retirement if retiring under an Involuntary Disability Retirement.

BD-0108-0405

PO Box 297
Trenton, NJ 08625-0297

POLICE AND FIREMEN'S RETIREMENT SYSTEM
NEW JERSEY DIVISION OF PENSIONS AND BENEFITS

APPLICATION FOR DISABILITY RETIREMENT

PLEASE READ THE ATTACHED INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS APPLICATION.
PLEASE DETACH BEFORE MAILING THE APPLICATION.

PART ONE: MEMBER INFORMATION (Please print - black ink preferred - or type.)

1. **MEMBERSHIP NUMBER** _____

2. **SOCIAL SECURITY NO.** _____ 3. **DATE OF BIRTH** _____
Month Day Year

4. **NAME** _____
Last First Middle

5. **ADDRESS** _____
Street Apt. No.

_____
City State Zip

6. **HOME PHONE** (_____) _____ 7. **CELL PHONE** (_____) _____
Area Code Area Code

8. **HOME E-MAIL ADDRESS** _____

DETACH HERE

PART TWO: DISABILITY RETIREMENT INFORMATION

9. **RETIREMENT DATE** — To be effective the first day of _____
Month Year

10. **TYPE OF DISABILITY RETIREMENT** — See enclosed Fact Sheet #16 for an explanation of each type.

☐ **ORDINARY DISABILITY** (Complete item #12) ☐ **SPECIAL DISABILITY** (Complete item #12)

☐ **ACCIDENTAL DISABILITY** (Complete items #12 and 13) **-** *Application must be filed within five years of date of accident.*

Date of Accident(s) 1.)_____ 2.)_____
Month Day Year Month Day Year

11. **Has a claim been filed for Workers' Compensation?** ☐ **NO** ☐ **YES**

12. I declare that I am **incapacitated** for further service as a _____
Title of Position

due to the following reasons: _____

_____

_____

13. ***(Accidental Disability Only)*** Describe the accident(s) and list any witnesses to it. _____
(You must also submit all accident reports for all accidents on which you are filing.)

_____

_____

14. **PURCHASE INFORMATION** — Have you applied to purchase pension service credit within the past six months? ☐ **YES** ☐ **NO**

PART THREE: Marital Status and Children

15. ☐ Single ☐ Married ☐ Domestic Partner ☐ Widowed ☐ Separated ☐ Divorced

16. Name of Spouse or Domestic Partner _____ (_____)
Last First MI (Maiden Name)

17. Spouse or Domestic Partner's SSN _____

18. Spouse or Domestic Partner's Mailing Address (if different from yours)

_____
Street Address City State Zip Code

19. Children: List any unmarried children under 18 years of age. Be sure to indicate both the gender and birth date of each child *(see instructions for definition of children)*.

Name _____ _____ _____
Last First MI Gender Date of Birth

Name _____ _____ _____
Last First MI Gender Date of Birth

Name _____ _____ _____
Last First MI Gender Date of Birth

PART FOUR: Designation of Group Life Insurance Beneficiary

PRIMARY BENEFICIARY(IES)

	BENEFICIARY NAME(S)	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NUMBER (Optional)
1.	_____	_____	_____	_____
	ADDRESS _____			
2.	_____	_____	_____	_____
	ADDRESS _____			

CONTINGENT BENEFICIARY(IES) — *If no Primary Beneficiary is living at my death, payment is to be made to:*

	BENEFICIARY NAME(S)	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NUMBER (Optional)
1.	_____	_____	_____	_____
	ADDRESS _____			
2.	_____	_____	_____	_____
	ADDRESS _____			

(Attach additional sheets for 3 or more beneficiaries. Additional sheets must be signed and dated.)

MEMBER'S SIGNATURE **DATE**

_____ _____, 20 _____

I attest that the information provided on this application is true and correct.

BD-0021-0704

State of New Jersey — Department of the Treasury
Division of Pensions and Benefits • PO Box 297 • Trenton, NJ 08625-0297 • (609) 292-7524

MEDICAL EXAMINATION BY PERSONAL OR TREATING PHYSICIAN

This form must be filed in support of an Application for Disability Retirement and is restricted to the confidential use of the retirement system.

PART ONE — *APPLICANT* (COMPLETE PART ONE BEFORE PRESENTING THIS FORM TO THE PHYSICIAN.)

Name _____ Date of Birth _____
Last, First, Middle Initial *Month, Day, Year*

Social Security Number _____ Job Title _____

PART TWO — *PHYSICIAN* (PLEASE TYPE OR PRINT CLEARLY.)

Please complete this form in its entirety. You may include copies of office notes to provide additional documentation but **each question must be answered on this form.** An incomplete form will be returned to the member and will delay processing of the application.

1. History of the illness or injury causing the disability and any other pertinent past or present history:

2. Positive physical findings:

3. Significant laboratory, cardiographic, x-ray or other diagnostic data: (If available, please attach copies of narrative reports only. No films please.)

4. Diagnosis:

5. Is the applicant totally and permanently disabled and no longer able to perform his or her job duties:

☐ NO ☐ YES

If Yes, explain in what way the applicant's symptoms or physical findings prevent him or her from working:

6. a) Is the applicant's disability likely to be stable or progressive? ☐ Stable ☐ Progressive

b) If progressive, is death imminent? ☐ NO ☐ YES

c) Is there a possibility that the applicant might improve to a degree to perform the applicant's duties?

☐ NO ☐ YES

7. Is the applicant permanently and totally disabled as a direct result of an accident that occurred during the performance of the applicant's regular assigned duties?

☐ NO ☐ YES

If yes, explain the causal relationship:

(PLEASE TYPE OR PRINT CLEARLY.)

Physician's Name:_____ Degree: _____

Address:_____

_____ Phone: (_____) _____

Specialty: _____ NJ License Number: _____

_____ _____

Signature of Physician *Date*

BD-0021-0704

State of New Jersey — Department of the Treasury
Division of Pensions and Benefits • PO Box 297 • Trenton, NJ 08625-0297 • (609) 292-7524

MEDICAL EXAMINATION BY PERSONAL OR TREATING PHYSICIAN

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PART ONE — *APPLICANT* (COMPLETE PART ONE BEFORE PRESENTING THIS FORM TO THE PHYSICIAN.)

Name _____ Date of Birth _____
Last, First, Middle Initial *Month, Day, Year*

Social Security Number _____ Job Title _____

PART TWO — *PHYSICIAN* (PLEASE TYPE OR PRINT CLEARLY.)

Please complete this form in its entirety. You may include copies of office notes to provide additional documentation but **each question must be answered on this form.** An incomplete form will be returned to the member and will delay processing of the application.

1. History of the illness or injury causing the disability and any other pertinent past or present history:

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3. Significant laboratory, cardiographic, x-ray or other diagnostic data: (If available, please attach copies of narrative reports only. No films please.)

4. Diagnosis:

5. Is the applicant totally and permanently disabled and no longer able to perform his or her job duties:

☐ NO ☐ YES

If Yes, explain in what way the applicant's symptoms or physical findings prevent him or her from working:

6. a) Is the applicant's disability likely to be stable or progressive? ☐ Stable ☐ Progressive

b) If progressive, is death imminent? ☐ NO ☐ YES

c) Is there a possibility that the applicant might improve to a degree to perform the applicant's duties?

☐ NO ☐ YES

7. Is the applicant permanently and totally disabled as a direct result of an accident that occurred during the performance of the applicant's regular assigned duties?

☐ NO ☐ YES

If yes, explain the causal relationship:

(PLEASE TYPE OR PRINT CLEARLY.)

Physician's Name:_____ Degree: _____

Address:_____

_____ Phone: (_____) _____

Specialty: _____ NJ License Number: _____

_____ _____

Signature of Physician *Date*

RM-0211-0704

State of New Jersey • Department of the Treasury
Division of Pensions and Benefits • PO Box 297 • Trenton, NJ 08625-0297 • (609) 292-7524

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____

Telephone _____

☐ If you were **not** hospitalized for your disability, check this box and return this form to the Division of Pensions and Benefits along with your *Application for Disability Retirement*. In that case, medical examination reports from two physicians must be submitted before a determination can be made.

I hereby authorize _____
Name of Hospital
to release my health information to the Division of Pensions and Benefits, PO Box 297, Trenton, NJ 08625-0297.

The information to be disclosed to and used by the above is for the purpose of determining eligibility for disability retirement.

This authorization is limited to the following dates of treatment:

From _____ To _____

A *Discharge Summary* must be included along with the following as indicated:

☐ EMERGENCY ROOM RECORD
☐ HISTORY & PHYSICAL EXAM
☐ OPERATIVE REPTS & PATHOLOGY
☐ CONSULTATIONS
☐ PROGRESS NOTES
☐ LAB, X-RAYS & TESTS
☐ PATHOLOGY SLIDES
☐ COMPLETE RECORD
☐ EEG TRACINGS
☐ OTHER _____

I understand that the information to be disclosed includes my identity, diagnosis and treatment, including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED AND INFECTIOUS DISEASES, AIDS and HIV information, as applicable.

It is my intent that the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Hospital named above. I understand that this revocation will not apply to the extent that you have already taken action in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date _____.

IF THERE IS ANY CHARGE FOR THIS SERVICE, I WILL REIMBURSE THE HOSPITAL.
DO NOT SEND BILLS FOR SERVICE TO THE DIVISION OF PENSIONS AND BENEFITS.

Patient Signature _____ Date _____

BD-0108-0405

STATE OF NEW JERSEY - DIVISION OF PENSIONS AND BENEFITS

AUTHORIZATION FOR DIRECT DEPOSIT OF BENEFIT PAYMENT

INSTRUCTIONS:

A: Read the terms and conditions listed below.
B: Enter your name, mailing address, pension membership number, Social Security number, and home telephone number.
C Mark the account type box, and print the financial institution's account number, routing number, and name and address where indicated. Be sure to double-check your account and 9-digit routing numbers before submitting this form — inaccurate information will delay processing of this application or your payment.
D: You and all other parties to this account must sign the form.
E: Attach a VOIDED check or deposit slip and **return the completed form with your *Application for Disability Retirement.***

RECIPIENT INFORMATION — Please Print Legibly

Your Name: _____ Membership No: _____

Your Address: _____ Social Security No: _____

_____ Home Phone No: _____

TYPE OF PAYMENT: ☒ RETIREMENT PAYMENT

_____
Your Account Number

TYPE OF ACCOUNT: ☐ CHECKING ☐ SAVINGS

_____
Financial Institution's 9-digit Routing Number

_____
Name of Financial Institution

_____
Street of Financial Institution

_____
City, State, ZIP Code of Financial Institution

_____
Your Signature and Date

_____ _____
Signature(s) of Other Persons On Account and Date(s)

Please read the terms and conditions below and
ATTACH A VOIDED CHECK IF AUTHORIZING A CHECKING ACCOUNT
(used to verify your financial institution's routing and account number)

TERMS AND CONDITIONS

Benefit Recipient

I authorize the New Jersey Division of Pensions and Benefits and the financial institution indicated to directly deposit my net retirement allowance payment each month to the account specified. Direct deposit under this authorization is full satisfaction and discharge of the amount then due and payable under the retirement system or benefit program. I understand that the provisions of the statutes governing the pension funds prohibit the deposit of retirement payments to a trust fund. I understand that any retirement allowance payment forwarded to the financial institution with a due date after my death will be refunded to the appropriate retirement system. I agree that the financial institution shall have the right of offset for such a refund.

I further understand that this agreement may be changed by me upon written notification to the Division of Pensions and Benefits. The change will be processed for the pay period following receipt of the notice by the Division. I understand that a change in the title of this account which alters the interest of any party terminates this authorization, a notification must then be submitted. I understand that it is my responsibility to inform the Division of Pensions and Benefits of address changes immediately. I authorize the financial institution to provide the Division of Pensions and Benefits with my home address.

Other Parties to the Account

As a party to this account, I understand that I am personally liable, both individually and as a member of the group of parties to this account, for the full amount of all retirement allowance payments with due dates after the death of the benefit recipient withdrawn from the account. This liability is to the retirement system. If I am entitled to any benefit from the retirement system or benefit program as a beneficiary of the benefit recipient, the amount of my liability may be deducted from the amount payable to me. I agree that the financial institution shall have the right of offset for such a refund and I authorize the financial institution to provide the Division of Pensions and Benefits with my home address.

RM-0212-0704

State of New Jersey — Department of the Treasury
Division of Pensions and Benefits • PO Box 297 • Trenton, New Jersey 08625-0297 • (609) 292-7524

EMPLOYER CERTIFICATION FOR DISABILITY RETIREMENT

1. **TO: Board of Trustees** *(Check appropriate fund)* ☐ PERS ☐ TPAF ☐ PFRS ☐ SPRS ☐ JRS

2. _____ **NAME OF EMPLOYEE**
_____ **TITLE** *(Attach copy of job description - PERS only)*
_____ **SOCIAL SECURITY NUMBER**
_____ **MEMBERSHIP NUMBER**
_____ **NAME OF EMPLOYER**
_____ **EMPLOYER'S ADDRESS**
_____ **EMPLOYER'S ADDRESS** *(Continued)*
_____ **EMPLOYER'S PHONE NUMBER**

3. **Date employee's service terminated** (Applicant will not render any service to or earn salaries, wages, fees or other compensation from this agency after this date.) _____

4. **EMPLOYEE STATUS** ☐ Full-Time ☐ Part-Time

5. **AUTHORIZED LEAVE OF ABSENCE**

☐ Paid Sick Leave - Dates from _____ to _____

☐ Paid Personal Leave - Dates from _____ to _____

☐ Unpaid Sick Leave - Dates from _____ to _____

☐ Unpaid Personal Leave - Dates from _____ to _____

☐ Temporary Disability Insurance - Dates from _____ to _____

6. **UNAUTHORIZED LEAVE OF ABSENCE** — Dates from _____ to _____

7. a) **Is the member currently on suspension?** ☐ NO ☐ YES If yes, give date of suspension _____
Is suspension ☐ PAID or ☐ UNPAID

b) **Is the applicant facing disciplinary action?** ☐ NO ☐ YES *If yes, attach copies of the preliminary and final notices of disciplinary action or their equivalents.*

c) **Is the applicant facing indictment?** ☐ NO ☐ YES *If yes, attach a copy of the indictment.*

8. Was applicant dismissed? ☐ NO ☐ YES *If yes, give reason and date* _____

TYPE OF DISABILITY RETIREMENT *(Select One)* — ☐ ORDINARY ☐ ACCIDENTAL *(Give dates of accident(s) below)*

1)_____ 2) _____ 3) _____ 4) _____

9. **IF THE EMPLOYEE IS FILING FOR AN *ACCIDENTAL* DISABILITY RETIREMENT, PLEASE COMPLETE THE SECTION BELOW**

a) Did this accident occur during the performance of the employee's duties? ☐ NO ☐ YES

b) Is a record of this accident on file? ☐ NO ☐ YES *If yes, attach copy of accident report, including any witness statements.*

c) Was this accident a result of the employee's negligence? ☐ NO ☐ YES

d) Has the employee filed a claim for Workers' Compensation? ☐ NO ☐ YES
If yes, dates of periodic payments from _____ to _____

NAME OF WORKERS' COMPENSATION CARRIER _____

ADDRESS_____ CLAIM NUMBER _____

PLEASE COMPLETE ALL ITEMS ON THE REVERSE SIDE OF THIS FORM

RM-0212-0704

EMPLOYER CERTIFICATION FOR DISABILITY RETIREMENT

10. Base salary subject to pension fund contributions paid for the last full year of service ending on the date of termination (line 3 above); please list number of months at a particular salary and show a total of 12 months for a 12-month employee or 10 months for a 10-month employee.

TOTAL

_____months @ $ _____ from _____ to _____ $ _____

_____months @ $ _____ from _____ to _____ $ _____

_____months @ $ _____ from _____ to _____ $ _____

_____months @ $ _____ from _____ to _____ $ _____

TOTAL BASE SALARY PAID FOR LAST YEAR OF SERVICE $_____

11. Has member received a significant annual salary increase in the last 3 years of employment? ☐ NO ☐ YES *If yes, please provide a detailed explanation with documentation such as salary guides and employment contracts and ruling body minutes.*

12. Has there been any retroactive salary paid to the employee within the past three years? ☐ NO ☐ YES *If yes, please describe below:*

AMOUNT OF PAYMENT		DATE OF PAYMENT	COVERING THE DATES (FROM - TO)	PENSION DEDUCTION		NEW ANNUAL BASE	
$			TO	$		$	
$			TO	$		$	
$			TO	$		$	

13. The following deductions have been made or will be made from the member's base salary during the final two quarterly periods including the quarter in which service terminated (see QUARTERLY REPORT OF CONTRIBUTIONS).

State biweekly reporting agencies should attach a screen print of TREADHOC biweekly certification with salaries projected until termination date in lieu of Item 13.

QUARTER ENDING	BASE SALARY SUBJECT TO CONTRIBUTIONS THIS QUARTER		PENSION CONTRIBUTION		LOAN REPAYMENT		BACK DEDUCTIONS NO. PAY-MENTS	BACK DEDUCTIONS AMOUNT		ARREARS AND/OR PURCHASES		TOTAL PENSION DEDUCTIONS	
	$		$		$			$		$		$	
	$		$		$			$		$		$	

✔ CHECKLIST — The following items must accompany this form:

_____ **1. Job Description (mandatory - PERS only)**

_____ **2. Copies of indictments, convictions, and/or preliminary and final notices of disciplinary action. (If Question #7 is answered yes.)**

_____ **3. Copies of accident reports, incident reports, witness statements, medical records relating to the incident, and other related documents (Accidental Disability only).**

_____ **4. Copies of Workers' Compensation awards (Accidental Disability only).**

Name of Certifying Officer _____ Phone Number (_____) _____

By signing this statement I am certifying, under penalty of perjury, to the truthfulness of the information contained herein.

Certifying Officer Signature _____ Date _____

NOTE: If a member of the retirement system qualifies for periodic benefits payable under the Workers' Compensation law during the course of active employment, regular pension contributions must be paid to the system by the employer. The payments are computed on the base salary paid immediately prior to the receipt of Workers' Compensation benefits. These payments are credited to the member's account in the system and will be treated as employee contributions for all benefit or claim purposes.

BD-0108-0405

State of New Jersey
Department of the Treasury
Division of Pensions and Benefits
PO Box 297, Trenton, NJ 08625-0297

CHANGE OF DISABILITY RETIREMENT
POLICE AND FIREMEN'S RETIREMENT SYSTEM

These changes can only be made before the retirement is due and payable.
This form cannot be used with an Involuntary Disability retirement.

Membership Number _____ Social Security Number_____

Name _____

Address _____

_____

☐ Check here if this is a new address.

I previously filed an *Application for Disability Retirement* with the Division of Pensions and Benefits.

I wish to make the following change to that application (check box that applies):

☐ **Change Retirement Date** — I wish to change the effective date of my retirement from:

_____ to _____ (May be any first of the month after the receipt date of the original *Application for Disability Retirement.* ***Your employer must complete the salary certification on the back of this form.***)

☐ **Cancel Retirement** — I wish to cancel my retirement which was to be effective on

_____. I will continue in employment. (Canceling your retirement does not guarantee continued employment with your employer.) I understand that this application cannot be reinstated and that I must file a new retirement application when I apply again on a future date. I further understand that the beneficiaries designated on my retirement application will remain in effect until I change them by submitting a new *Designation of Beneficiary* form or a new retirement application.

Once your disability retirement is approved by the Board of Trustees you cannot cancel your retirement, and your application cannot be withdrawn, cancelled, or amended.

_____ _____

Signature Date

BD-0108-0405

CHANGE OF DISABILITY RETIREMENT
EMPLOYER CERTIFICATION

1. _____ _____
NAME OF EMPLOYEE **NAME OF EMPLOYER**

_____ _____
SOCIAL SECURITY NUMBER **EMPLOYER'S PHONE NUMBER**

_____
MEMBERSHIP NUMBER

The employee named above has elected to change his/her retirement date to the date shown on the front of this form.

- **If you have already submitted** a *Certification for Disability Retirement* for the former date to the Division of Pensions and Benefits, please complete this form and return it to the Division.
- **If you have not already submitted** a *Certification for Disability Retirement,* **YOU CANNOT USE THIS FORM.** Instead, you **must** complete a *Certification for Disability Retirement* in it's entirety and return it with this Change Request form to the Division.

2. **Date employee's service terminated** (Applicant will not render any service to or earn salaries, wages, fees or other compensation from this agency after this date.) _____

3. **Base salary subject to pension fund contributions** paid for the last full year of service ending on the date of termination (line 2 above); please list number of months at a particular salary and show a total of 12 months for a 12-month employee or 10 months for a 10-month employee.

TOTAL

_____months @ $ _____ from _____ to _____ $ _____

_____months @ $ _____ from _____ to _____ $ _____

_____months @ $ _____ from _____ to _____ $ _____

_____months @ $ _____ from _____ to _____ $ _____

TOTAL BASE SALARY PAID FOR LAST YEAR OF SERVICE $ _____

4. The following deductions have been made or will be made from the member's base salary during the final two quarterly periods including the quarter in which service terminated (see QUARTERLY REPORT OF CONTRIBUTIONS).

State biweekly reporting agencies should attach a screen print of TREADHOC biweekly certification with salaries projected until termination date in lieu of Item 4.

QUARTER ENDING	BASE SALARY SUBJECT TO CONTRIBUTIONS THIS QUARTER	PENSION CONTRIBUTION	LOAN REPAYMENT	BACK DEDUCTIONS		ARREARS AND/OR PURCHASES	TOTAL PENSION DEDUCTIONS
				NO. PAY-MENTS	AMOUNT		
	$	$	$		$	$	$
	$	$	$		$	$	$

Name of Certifying Officer _____ Phone Number (_____) _____

By signing this statement I am certifying, under penalty of perjury, to the truthfulness of the information contained herein.

Certifying Officer Signature _____ Date _____

BD-0108-0405