RETIREMENT APPLICATION

PUBLIC SCHOOL RETIREMENT SYSTEM OF THE CITY OF ST. LOUIS (PSRSSTL)
3641 OLIVE STREET, SUITE 300, ST. LOUIS, MO 63108-3601
TELEPHONE: (314) 534-7444

Please type or print in ink. You MUST complete every section of this form. You MUST sign and date Sections 2, 3, 4 and 5. PSRSSTL must receive this Application AT LEAST 15 days prior to your Retirement Effective Date. Late receipt of this Retirement Application will cause your Retirement Effective Date to be delayed. To obtain a quote under Benefit Payment Option 5, 6 or 7, you must provide an estimate from Social Security of your benefit amount at age 62. The beneficiary designations you make on this Retirement Application will replace any designations on file with PSRSSTL effective on your Retirement Effective Date.

SECTION 1. PERSONAL INFORMATION

YOUR NAME _____ SEX ☐ MALE ☐ FEMALE

STREET ADDRESS _____ MARITAL STATUS _____

CITY/STATE/ZIP _____ BIRTH DATE _____

SOC. SEC. NO. _____ PERSONNEL NUMBER _____ AGE AT RETIREMENT _____

JOB TITLE _____ WORK PHONE _____

EMPLOYMENT TYPE ___ 10 MONTH ___ 10.5 MONTH ___ 11 MONTH ___ 12 MONTH HOME PHONE _____

SECTION 2. APPLICATION FOR PENSION BENEFITS

ENTER THE LAST DAY FOR WHICH YOU EXPECT TO BE PAID BY YOUR EMPLOYER *(include salary, sick leave, etc.)* _____

ENTER THE EFFECTIVE DATE OF YOUR RETIREMENT *(must be **"beginning of day"** the first day of a month)* _____

X _____ X _____

Your Signature ***Date of Signature***

SECTION 3. BENEFIT PAYMENT OPTIONS

☐ **I <u>DO NOT</u> ELECT A BENEFIT PAYMENT OPTION.** IF YOU CHECK THIS BOX, YOU MUST SIGN AND DATE BELOW AND INITIAL HERE. _____

☐ **I <u>DO</u> ELECT A BENEFIT PAYMENT OPTION.** I UNDERSTAND THAT IF I ELECT TO RECEIVE MY RETIREMENT BENEFITS UNDER ONE OF THE SURVIVOR PAYMENT OPTIONS DESCRIBED BELOW, MY BENEFITS WILL BE REDUCED IN ORDER TO PROVIDE MONTHLY PAYMENTS TO MY OPTION BENEFICIARY AFTER MY DEATH. I UNDERSTAND THAT I MAY NOT CHANGE MY PAYMENT OPTION OR MY OPTION BENEFICIARY AFTER MY RETIREMENT BENEFIT PAYMENTS BEGIN. I ALSO UNDERSTAND THAT IF I SELECT ONE OF THE SURVIVOR PAYMENT OPTIONS BELOW, I MUST PROVIDE PSRSSTL WITH A COPY OF THE BIRTH CERTIFICATE AND SOCIAL SECURITY CARD OF MY OPTION BENEFICIARY AT LEAST 15 DAYS PRIOR TO MY RETIREMENT EFFECTIVE DATE.

(Place a check mark in the appropriate box to indicate the Payment Option you are electing. Provide Option Beneficiary information and sign and date below.)

☐ **Option 1** If the Option Beneficiary I have designated below is still living at the time of my death, my reduced monthly benefit payments shall continue to my Option Beneficiary on a monthly basis for his/her lifetime.

☐ **Option 2** If the Option Beneficiary I have designated below is still living at the time of my death, half of the amount of my reduced monthly benefit payments shall continue to my Option Beneficiary on a monthly basis for his/her lifetime.

☐ **Option 3** The same as Option 1, except that, if my Option Beneficiary dies before I do, effective the first day of the month following my Option Beneficiary's death, my reduced monthly benefit will be increased to the amount I would have received at the time of my retirement had I not elected this Benefit Payment Option.

☐ **Option 4** The same as Option 2, except that, if my Option Beneficiary dies before I do, effective the first day of the month following my Option Beneficiary's death, my reduced monthly benefit will be increased to the amount I would have received at the time of my retirement had I not elected this Benefit Payment Option.

☐ **Option 5** My monthly benefit prior to age 62 shall be increased so that my pension prior to age 62 shall be approximately equal to the sum of my pension after age 62 plus my estimated federal Social Security benefit.

☐ **Option 6** My monthly benefit shall be a combination of Benefit Payment Option 1 and Benefit Payment Option 5.

☐ **Option 7** My monthly benefit shall be a combination of Benefit Payment Option 2 and Benefit Payment Option 5.

_____ _____

Name of Option Beneficiary ***Option Beneficiary's Social Security Number***

_____ _____

Relationship ***Option Beneficiary's Date of Birth***

_____

Option Beneficiary: Street Address, City, State, Zip Code

X _____ X _____

Your Signature ***Date of Signature***

Over, please

PEN.APP.2.2007

OFFICE USE ONLY: ELIGIBILITY DETERMINED _____ VERIFIED _____ TO INS. DEPT. _____

SECTION 4. BENEFICIARY DESIGNATION

COMPLETE THIS SECTION 4 EVEN IF YOU NAMED AN OPTION BENEFICIARY IN SECTION 3. IF YOU ELECTED A SURVIVOR BENEFIT PAYMENT OPTION AND NAMED AN OPTION BENEFICIARY IN SECTION 3, YOU SHOULD DESIGNATE A DIFFERENT BENEFICIARY(IES) IN THIS SECTION 4.

If I die (or if my Option Beneficiary and I both die) before the sum total of pension benefits which have been paid equals or exceeds my contributions to PSRSSTL, plus accumulated interest thereon, the difference will be paid to the Primary Beneficiary(ies) named below; however, if my Primary Beneficiary(ies) is not living, the difference will be paid to the Contingent Beneficiary(ies) named below.

Primary Beneficiary(ies)

Name of Primary Beneficiary | *Relationship* | *Soc. Sec. No.* | *Date of Birth*

Street Address, City, State, Zip Code

Name of Primary Beneficiary | *Relationship* | *Soc. Sec. No.* | *Date of Birth*

Street Address, City, State, Zip Code

Contingent Beneficiary(ies)

Name of Contingent Beneficiary | *Relationship* | *Soc. Sec. No.* | *Date of Birth*

Street Address, City, State, Zip Code

Name of Contingent Beneficiary | *Relationship* | *Soc. Sec. No.* | *Date of Birth*

Street Address, City, State, Zip Code

X _____ *Your Signature*

X _____ *Date of Signature*

SECTION 5. HEALTH CARE INSURANCE INFORMATION

INDICATE BELOW IF YOU WOULD LIKE INFORMATION ON THE MEDICAL, DENTAL AND/OR VISION INSURANCE PLANS OFFERED BY PSRSSTL. YOU MAY ONLY ENROLL FOR PSRSSTL-SPONSORED INSURANCE (1) UPON YOUR RETIREMENT, (2) DURING THE OPEN ENROLLMENT PERIOD IMMEDIATELY FOLLOWING YOUR ELIGIBILITY FOR MEDICARE PART A, OR (3) WITHIN THIRTY DAYS OF YOUR INVOLUNTARY LOSS OF OTHER GROUP COVERAGE. ENROLLMENT FORMS AND BENEFIT INFORMATION ABOUT THE INSURANCE PROGRAMS YOU INDICATE BELOW WILL BE MAILED TO YOU UNDER SEPARATE COVER.

Medical Insurance

I would like information on medical insurance. ❑ **Yes** ❑ **No**

As of your retirement date, will you or any of the dependents you wish to enroll for medical insurance be entitled to Medicare insurance benefits due to age or disability status with the Social Security Administration? If yes, contact PSRSSTL immediatley.

Medicare-entitled members and dependents must have both Part A and Part B coverage to be eligible to enroll for PSRSSTL insurance. ❑ **Yes** ❑ **No**

Provide the name of the medical plan under which you are currently covered through St. Louis Public Schools.

_____

Dental Insurance

I would like information on dental insurance. ❑ **Yes** ❑ **No**

Vision Insurance

I would like information on vision insurance. ❑ **Yes** ❑ **No**

X _____ *Your Signature*

X _____ *Date of Signature*