Disability Retirement Election Application

888 CalPERS (or **888**-225-7377) • TTY (877) 249-7442

Employer Information

☐ Check if this is an employer-originated application.
Employer must fill out and sign Section 12 on the last page of this application.

Application Type

☐ Disability Retirement
☐ Service Pending Disability Retirement
☐ Industrial Disability Retirement
☐ Service Pending Industrial Disability Retirement

Section 1 — Information About You

Please provide your name as it appears on the Social Security card.

Name of Member (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Address

City | State | ZIP | Country

Please display all dates in this order: month/day/year.

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | ( ) Home Phone | ( ) Alternate Phone

Section 2 — Information About Your Retirement

Please refer to the detailed instructions in this publication.

Last Day on Payroll (mm/dd/yyyy) | Retirement Effective Date (mm/dd/yyyy)

Please do not abbreviate your employer's name or position title.

Employer | Position Title

Other California Public Retirement Systems

Do not include Social Security, military, or railroad retirement.

Are you a member of a California public retirement system other than CalPERS? ☐ No ☐ Yes, provide:

Name of System

Are you currently working with the other system? ☐ No ☐ Yes

Date of Retirement with Other System (mm/dd/yyyy)

Put your name and Social Security number or CalPERS ID at the top of every page.

Your Name | Social Security Number or CalPERS ID

Section 3

Disability Information

Please complete all the questions below. If you need additional space, attach separate sheets and be sure to include your name and Social Security number or CalPERS ID on all sheets.

Local Safety members should not complete Section 3.

What is your specific disability? _____

When did the disability occur? (mm/dd/yyyy) _____

How did the disability occur? _____

What are your limitations/preclusions due to your injury or illness? _____

How has your injury or illness affected your ability to perform your job? _____

Are you currently working in any capacity? ☐ No ☐ Yes

If yes, what is your employment status? ☐ Full time ☐ Part time

Job duties: _____

Other information you would like to provide: _____

If you indicated a third-party liability, CalPERS will require additional information.

Did a third party cause your injury? ☐ No ☐ Yes (If yes, CalPERS has a potential "right of subrogation.")

Section 4

Treating Physician Detail

Local Safety members should not complete Section 4.

What is the complete name and address of your treating physician(s)?

First Name | Last Name | Your Medical Record Number

Address

City | State | ZIP | Country

Specialty | Secondary Specialty | ( ) Phone Number

Put your name and Social Security number or CalPERS ID at the top of every page.

Your Name | Social Security Number or CalPERS ID

Section 5

Select Your Retirement Payment Option and Beneficiary

Select **only one** payment option: Option 1, Option 2, Option 2W, Option 3, Option 3W, the Unmodified Allowance Option, or one of the Option 4 types.

By filling out this section, you are electing your Retirement Payment Option and designating your beneficiary. Your payment option election and lifetime beneficiary(ies) designation is irrevocable unless you request a change within 30 days of the issuance of your first benefit check or you have a future qualifying event. Along with your option selection, you must complete at least one of the beneficiary designations in Sections 5a–5d. Please refer to the detailed instructions in this publication for more information.

☐ **Option 1** – To complete this option, you must also fill out Section 5d, *Balance of Contributions Beneficiary(ies).*

☐ **Option 2** – To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

☐ **Option 2W** – To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

☐ **Option 3** – To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

☐ **Option 3W** – To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

☐ **Unmodified Allowance Option** – If you select this option there is no return of your member contributions and no monthly benefits payable upon your death – except the Survivor Continuance benefit, if applicable. There is no beneficiary designation for this option.

These options apply to Option 4 **Individual Lifetime Beneficiary** only.

☐ **Option 4, Individual Lifetime Beneficiary** – If you select this option, you must also select one of the following Individual Lifetime Beneficiary options below.

- ☐ **Option 2W & Option 1 Combined** – To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary* and Section 5d, *Balance of Contributions Beneficiary(ies)*.
- ☐ **Option 3W & Option 1 Combined** – To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary* and Section 5d, *Balance of Contributions Beneficiary(ies)*.
- ☐ **Specific Dollar Amount to Beneficiary** $_____ (Dollars) – To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary.*
- ☐ **Specific Percentage to Beneficiary** _____ (Percent)% – To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary.*
- ☐ **Reduced Allowance for Fixed Period of Time**

  Reduce my Allowance by $_____ (Dollars) or _____ (Percent) % through the end of _____ (Date (mm/yyyy)).

  To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- ☐ **Reduced Allowance upon death of retiree or beneficiary:** $_____ (Dollars) **reduction amount**

  To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

This option applies to Option 4 **Multiple Lifetime Beneficiaries** only.

☐ **Option 4, Multiple Lifetime Beneficiaries** – To complete this option choice, you must also fill out Section 5b, *Option 4 Multiple Lifetime Beneficiaries.*

☐ **Option 4, Court Ordered Community Property** – If you select this option, you must also complete Section 5c, *Court Ordered C.P. Beneficiary* and select one of the following Court Ordered Option 4 Community Property options.

These options apply to Option 4, **Court Ordered Community Property** only.

- ☐ **Option 4/Unmodified** – There is no additional beneficiary designation for this option.
- ☐ **Option 4/1** – To complete this option, you must also fill out Section 5d, *Balance of Contributions Beneficiary(ies).*
- ☐ **Option 4/2W** – To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- ☐ **Option 4/3W** – To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

Put your name and Social Security number or CalPERS ID at the top of every page.

Your Name | Social Security Number or CalPERS ID

Section 5a

Option 2, 2W, 3, 3W or 4 Individual Lifetime Beneficiary

Designate one beneficiary and provide all of that person's information including full name.

Complete this section only if you chose either Option 2, 2W, 3, 3W or Option 4 Individual Lifetime Beneficiary or Option 4/2W or 4/3W Court Ordered Community Property.

Name (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Section 5b

Option 4 Multiple Lifetime Beneficiaries

If you want your beneficiaries to receive an equal share of your benefits, do **not** specify a dollar or percentage of benefit.

If you are married or are in a registered domestic partnership, your spouse or domestic partner may be entitled to the community property interest in the option allowance payable to your designated beneficiary, according to law.

Complete this section **only** if you selected **Option 4 Multiple Lifetime Beneficiaries.**

Name (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You | Dollar/Percent of Benefit

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You | Dollar/Percent of Benefit

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You | Dollar/Percent of Benefit

Address

City | State | ZIP | Country

Section 5c

Court Ordered Option 4 Community Property Beneficiary

List **only** the Option 4 beneficiary that is required by your court order.

Complete this section **only** if you selected **Option 4 Court Ordered Community Property**.

Name (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Put your name and Social Security number or CalPERS ID at the top of every page.

Your Name | **Social Security Number or CalPERS ID**

Section 5d

Option 1 Balance of Contributions Beneficiary(ies)

Designate up to three beneficiaries here. If you want to designate more than three beneficiaries, you will need to complete the ***Post Retirement Lump Sum Beneficiary Designation*** form and follow the instructions on the form.

Complete this section only if you selected **Option 1**, **Option 4-2W/1** or **3W/1 combined**. You may change your beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. Please refer to the detailed instructions in this publication for more information.

Name (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Section 6

Retired Death Benefit

If you were last employed with another California public retirement system, this benefit is not payable.

This section designates the person who will receive your lump sum Retired Death Benefit. You may change your beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. Please refer to the detailed instructions in this publication for more information.

Name (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Section 6 continues on page 6

Put your name and Social Security number or CalPERS ID at the top of every page.

Your Name | Social Security Number or CalPERS ID

Section 6, continued

Retired Death Benefit

Name (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birthdate (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Section 7

Survivor Continuance

Please answer all five questions and complete the information in each section where you answered "Yes."

Please refer to the detailed instructions in this publication for more information.

1. Will you be married on your disability retirement date? ☐ No ☐ Yes, provide:

Name of Spouse (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Date of Marriage (mm/dd/yyyy)

Address

City | State | ZIP | Country

2. Will you be registered with the California Secretary of State as being in a domestic partnership on or before your disability retirement date? ☐ No ☐ Yes, provide:

Name of Domestic Partner (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Date of Registered Partnership (mm/dd/yyyy)

Address

City | State | ZIP | Country

3. Do you have any natural or adopted unmarried children under age 18? ☐ No ☐ Yes, provide:

Name of Child (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender

Address

City | State | ZIP | Country

Section 7, continued

Survivor Continuance

Name of Child (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender

Address

City | State | ZIP | Country

4. Do you have any unmarried children who were disabled prior to their 18th birthday and who are still disabled?
☐ No ☐ Yes, provide:

Name of Child (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender

Address

City | State | ZIP | Country

Name of Child (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender

Address

City | State | ZIP | Country

5. Are your parents dependent upon you for one-half of their support? ☐ No ☐ Yes, provide:

Name of Parent (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender

Address

City | State | ZIP | Country

Name of Parent (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender

Address

City | State | ZIP | Country

Put your name and Social Security number or CalPERS ID at the top of every page.

Your Name | Social Security Number or CalPERS ID

Section 8 Workers' Compensation Detail

Local safety members should not complete Section 8.

Do you have any workers' compensation claims? ☐ Yes ☐ No

Claim Number(s) | Date of Injury (mm/dd/yyyy) | Body Part(s)

Workers' Compensation Carrier

Adjuster: First Name | Last Name

( ) Phone Number | ( ) Fax | Email

Address of Workers' Compensation Claim Carrier

City | State | ZIP

Section 9 Tax Withholding Election

Please choose one only.

Federal Income Tax information. Please refer to the detailed instructions in this publication for more information.

☐ Do not withhold federal income tax.

☐ Withhold federal income tax based on the tax tables for:

- ☐ A married individual with _____ (Number) tax withholding allowances.
- ☐ A single individual with _____ (Number) tax withholding allowances.

In addition to the amount withheld based on the tax tables, withhold $_____ (Dollars) per month.

☐ A married individual, but withhold at the higher single rate with _____ (Number) tax withholding allowances.

State Income Tax information. Please refer to the detailed instructions in this publication for more information.

Please choose one only. State withholding is optional for out-of-state residents.

☐ Do not withhold State of California income tax.

☐ Withhold State of California income tax in the amount of $_____ (Dollars) per month.

☐ Withhold State of California income tax based on the tax tables for:

- ☐ A married individual with _____ (Number) tax withholding allowances.
- ☐ A single individual with _____ (Number) tax withholding allowances.

In addition to the amount withheld based on the tax tables, withhold $_____ (Dollars) per month.

☐ Withhold State of California income tax in the amount of 10 percent of the federal income tax withholding amount.

☐ A head of household individual with _____ (Number) tax withholding allowances.

Section 10 CalPERS Health Coverage

If you are currently enrolled in your own right for CalPERS health benefits, you can continue your health enrollment into retirement with no break in coverage.

If you **do not want health coverage**, you must cancel retiree health coverage by declining coverage below. You may be eligible to enroll in health coverage during the next Open Enrollment period.

☐ **I decline continuation of my CalPERS health coverage into retirement.**

Put your name and Social Security number or CalPERS ID at the top of every page.

Your Name | **Social Security Number or CalPERS ID**

Section 11

Member Signature and Notary

This section must be completed or your application will be returned.

Your signature and your spouse's or domestic partner's signature must be notarized by a notary public or witnessed by a CalPERS representative. If your spouse's or domestic partner's signature is not available, see instructions in this publication on completing the ***Justification for Absence of Signature*** form.

I certify, under the penalty of perjury, that the information submitted hereon is true and correct to the best of my knowledge. **I understand that to cancel this application or to change the elected payment option or lifetime beneficiary(ies) I must notify CalPERS within 30 days of the issuance of my first retirement benefit check.**

I understand that if I am married or in a registered domestic partnership, but do not name my spouse or partner as beneficiary, they may still be entitled to a community property share of the Option 1 lump sum return of contributions benefit **or** a share of the monthly option death benefit allowance. Their community property interest is 50 percent of the benefit based on the contributions or service credit earned for the period of CalPERS service during which we were married or in a registered partnership. My non-spouse or non-partner designated beneficiary will receive the portion of the lump sum Option 1 benefit or monthly option allowance that is not payable to my spouse or domestic partner. I understand that my spouse or domestic partner will have the right to disclaim entitlement to their community property interest in the death benefit at the time the benefit becomes payable, if they so desire.

More detailed information on this section is available in this publication.

Are you legally married or do you have a legal domestic partner? ☐ Yes ☐ No

If yes, your spouse or domestic partner must sign this election.

If no, please indicate: ☐ Never Married/or in Partnership ☐ Divorced/Annulled ☐ Widowed or Termination of Domestic Partnership

Your Signature | Date (mm/dd/yyyy)

Your Spouse's or Domestic Partner's Signature | Date (mm/dd/yyyy)

State of California, County of _____

On _____ (Date) before me, _____ (Name of Notary/Witness)

personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument. I certify under **Penalty of Perjury** under the laws of the State of California that the foregoing paragraph is true and correct.

Notary Seal

Witness my hand and official seal **or** authorized CalPERS representative signature.

Signature of Notary or CalPERS Representative | Position Title | Date (mm/dd/yyyy)

Print Name | CalPERS Office (if applicable)

Put your name and Social Security number or CalPERS ID at the top of every page.

Your Name | **Social Security Number or CalPERS ID**

Section 12

Employer-Originated Application

To be completed if the employer is submitting the application on behalf of the member.

Is employee working in any capacity? ☐ No ☐ Yes ☐ Full time ☐ Part time

Signature of Employer

Print Name of Employer

Position Title of Employer | Phone Number ( ) | Date (mm/dd/yyyy)

Mail to: **CalPERS Benefit Services Division** • P.O. Box 942711, Sacramento, California 94229-2711