Occupational Disability Packet

(TMRS-ODRP)

PURPOSE

In the event a member of TMRS becomes disabled, he or she may be entitled to "Occupational Disability" benefits if the employing city has adopted the benefit. The purpose of this packet is to allow you to apply for Occupational Disability Retirement benefits with TMRS. There is no minimum length of service or age required to be eligible. The cause of disability does not have to be job related.

The test for Occupational Disability is a finding by the TMRS Medical Board that:

- You are physically or mentally disabled for further performance of the duties of your particular occupation;
- The disability is likely to be permanent; and
- You should be retired.

FORMS INCLUDED IN THIS PACKET:

- Application for Occupational Disability Retirement (TMRS-15/O)
- City Statement (TMRS-40/OA)
- Member's Statement (TMRS-40/OB)
- Physician's Statement (TMRS-40/OC)
- Selection of Retirement Plan (TMRS-24)
- Acceptable Proofs of Birth (TMRS-27)
- Name Certification (TMRS-30)
- Electronic Direct Deposit Authorization (TMRS-80E)

Texas Municipal Retirement System
P.O. Box 149153
Austin, Texas 78714-9153

800.924.8677 • 512.476.7577 • FAX 512.476.5576 • www.TMRS.com

THE APPLICATION PROCESS

- The retirement date must be the last day of the calendar month, cannot precede the date you terminate employment, and cannot precede the date you file this application. Normally a member must apply for retirement not less than 30 days nor more than 90 days before the retirement date. By signing this application, you agree to waive any requirement to file the application at least 30 days before the effective date of your retirement.
- Your employing city may have specific requirements for you to notify them of your retirement. Notifying your city and applying to TMRS for retirement are two separate processes. Please coordinate your retirement with your city personnel office to ensure you have met the city's requirements.
- You must complete the following forms prior to the application being sent to the TMRS Medical Board for consideration:
  - Application for Occupational Disability Retirement • to be completed by you and certified by your employer
  - City Statement for Occupational Disability • to be completed by your employer
  - Member's Statement for Occupational Disability • to be completed by you
  - Physician's Statement for Occupational Disability • to be completed by your attending physician
  - A photocopy of your official job description
- You must complete the following forms before TMRS issues your first payment:
  - Selection of Retirement Plan
  - Your proof of birth (photocopy)
  - Proof of birth for your designated beneficiary — only if you choose one of the Retiree Life with Survivor Benefits options

    NOTE: *If the birth name on the proof of birth is different from the names provided on your application (for you or your beneficiary), a Name Certification form (TMRS-30, included in this packet) will need to be completed*

  - Electronic Direct Deposit Authorization — Retiring members must have their monthly annuity payments electronically
  - deposited to their financial institutions

IF YOU ARE ELIGIBLE FOR SERVICE RETIREMENT

- In many cases, you should consider applying for Service Retirement rather than Occupational Disability. The benefits are equal and Service Retirement places no restrictions on your earnings. An exception to this might occur if disability retirement would help your eligibility for early Medicare or similar benefits. You should contact TMRS for further information.
- You may choose to receive a Partial Lump Sum Distribution if you are eligible for a service retirement. If you choose to receive a Partial Lump Sum Distribution, you must also complete the Selection of Partial Lump Sum Distribution form and submit the form to TMRS prior to the mailing of your first payment.

RETURNING TO WORK

An Occupational Disability retiree may return to work either for the city or some other employer. However, your monthly benefit will be reduced if you are less than age 60 and if your earnings after retirement plus the disability retirement benefit exceed your compensation at the time of retirement. The monthly benefit will not be reduced below the amount of annuity that your own contributions would provide. Occupational Disability retirees may be required to submit yearly proof of any money received as salary, wages or other earnings along with federal tax form(s) W-2 or 1099.

IMPORTANT NOTE: *If you return to work in a position that is the same type of position you held when you retired, your monthly annuity will be discontinued and your account reinstated (example: a retired patrol officer cannot go back to work as a patrol officer).*

WHEN TO EXPECT PAYMENT

Retirement payments will begin the last day of the month following the effective date of retirement, if the TMRS Medical Board approves your application.

NOTE: *Monthly payments will be electronically deposited to your financial institution.*

NOTES TO PHYSICIAN

- All medical information you submit is for interpretation by actively practicing physicians to determine the member's disability status according to the laws governing the Texas Municipal Retirement System. The System needs the answers to all of the questions. Copies of a current history and physical, hospital discharge summary, narrative report or comprehensive consultation, or other pertinent information, may also provide helpful information to supplement specific answers to questions on the form.
- The City Statement for Occupational Disability **MUST BE ATTACHED** in order to complete the Physician's Statement. If the City Statement is not provided, please contact TMRS or your patient.

TMRS WILL NOT ACCEPT

- Illegible forms. All forms should be typed. Handwritten forms will be accepted only if legible and if completed in black ink
- Alterations without initials
- An incomplete form or any attempt to change its provisions

Application for Occupational Disability Retirement

TMRS®
TEXAS MUNICIPAL RETIREMENT SYSTEM

MEMBER INFORMATION

Please type or use only black ink and do not highlight. Any corrections must be initialed.

TMRS Identification Number (not required)

Member's Name (first, middle, last)

Social Security Number

Mailing Address

Daytime Phone Number

City | State | Zip

Employing City

I certify that **I was** ☐ **/ was not** ☐ a Public Safety Employee when I separated from service from the employing city listed below.
(Public Safety Employee is defined in the instructions provided with this form.)

I hereby make formal application for occupational disability retirement benefits in accordance with the provisions of the TMRS Act. Subject to a medical examination and approval by the Board of Trustees, this retirement to be effective on the last day of _____.
Date (MM/YYYY)

Note: *The retirement date must be the last day of the calendar month, cannot precede the date you terminate employment, and cannot precede the date you file this application. By signing the application below, you agree to waive any requirement to file the application at least 30 days before the effective date of your retirement. In addition, your city may have specific notification requirements. Please check with your city personnel office to ensure all city requirements have been satisfied.*

I do ☐ / **I do not** ☐ elect to receive a partial lump-sum distribution upon my retirement.
(You may elect to receive a partial lump-sum distribution only if you are eligible for a service retirement benefit.)

All lump-sum distributions will be made as a one-time payment, payable at the same time as the first monthly annuity payment. Election of the partial lump-sum distribution will reduce my monthly annuity payment.

MEMBER CERTIFICATION

I understand that once each year, until I attain the age of 60, I may be required to report to the TMRS Board the amount of any income I receive subject to taxation under the Federal Insurance Contribution Act (FICA). If the sum of my other income and the amount of my monthly occupational disability annuity exceeds the average compensation I received from the city during the highest 12 consecutive months of the 36 months preceding the year of my retirement, my monthly occupational disability will be reduced.

Member's Signature

Date Signed (MM/DD/YYYY)

EMPLOYER CERTIFICATION

I certify that the above named applicant is known to me and that he/she has been an employee of this city. I further certify that this applicant's employment with the city has terminated/will terminate **on** _____ and that all of the applicant's retirement contributions will have been submitted to TMRS with the city's payroll report for the **month of retirement**.
Date (MM/YYYY)

Signature of City Official

Date Signed (MM/DD/YYYY)

Printed Name and Title

Employing City

Please read the instructions provided with this form.

THE APPLICATION PROCESS

- The retirement date must be the last day of the calendar month, cannot precede the date you terminate employment, and cannot precede the date you file this application. Normally a member must apply for retirement not less than 30 days nor more than 90 days before the retirement date. By signing this application, you agree to waive any requirement to file the application at least 30 days before the effective date of your retirement.

- Your employing city may have specific requirements for you to notify them of your retirement. Notifying your city and applying to TMRS for retirement are two separate processes. Please coordinate your retirement with your city personnel office to ensure you have met the city's requirements.

- You must complete the following forms prior to the application being sent to the TMRS Medical Board for consideration:
  - Application for Occupational Disability Retirement • to be completed by you and certified by your employer
  - City Statement for Occupational Disability • to be completed by your employer
  - Member's Statement for Occupational Disability • to be completed by you
  - Physician's Statement for Occupational Disability • to be completed by your attending physician
  - A photocopy of your official job description

- You must complete the following forms before TMRS issues your first payment:
  - Selection of Retirement Plan
  - Your proof of birth (photocopy)
  - Proof of birth for your designated beneficiary — only if you choose one of the Retiree Life with Survivor Benefits options
    NOTE: *If the birth name on the proof of birth is different from the names provided on your application (for you or your beneficiary), a Name Certification form (TMRS-30) will need to be completed*
  - Electronic Direct Deposit Authorization — Retiring members must have their monthly annuity payments electronically deposited to their financial institutions

IF YOU ARE ELIGIBLE FOR SERVICE RETIREMENT

- In many cases, you should consider applying for Service Retirement rather than Occupational Disability. The benefits are equal, and Service Retirement places no restrictions on your earnings. An exception to this might occur if disability retirement would help your eligibility for early Medicare or similar benefits. You should contact TMRS for further information.

- You may choose to receive a Partial Lump Sum Distribution if you are eligible for a service retirement. If you choose to receive a Partial Lump Sum Distribution, you must also complete the Selection of Partial Lump Sum Distribution form and submit the form to TMRS before TMRS issues your first payment.

RETURNING TO WORK

An Occupational Disability retiree may return to work either for the city or some other employer. However, your monthly benefit will be reduced if you are less than age 60 and if your earnings after retirement plus the disability retirement benefit exceed your compensation at the time of retirement. The monthly benefit will not be reduced below the amount of annuity that your own contributions would provide. Occupational Disability retirees may be required to submit yearly proof of any money received as salary, wages or other earnings along with federal tax form(s) W-2 or 1099.

IMPORTANT NOTE: *If you return to work in a position that is the same type of position you held when you retired, your monthly annuity will be discontinued and your account reinstated (example: a retired patrol officer cannot go back to work as a patrol officer).*

WHEN TO EXPECT PAYMENT

Retirement payments will begin the last day of the month following the effective date of retirement, if the TMRS Medical Board approves your application.

NOTE: *Monthly payments will be electronically deposited to your financial institution.*

PUBLIC SAFETY EMPLOYEE

Under the 2006 Pension Protection Act, the 10% early withdrawal tax is waived for distributions made to public safety employees who separate from service during or after attaining age 50. A "qualified public safety employee" is defined as any employee of a state (or political subdivision) whose principal duties include services requiring specialized training in the area of police protection, fire-fighting services, or emergency medical services for any area within the jurisdiction of the state (or political subdivision). TMRS will require city certification from the city of last employment to qualify for this waiver. A certification form will be provided directly to the city once TMRS is notified that an employee may qualify.

TMRS WILL NOT ACCEPT

- Illegible forms. All forms should be typed. Handwritten forms will be accepted only if legible and if completed in black ink
- Alterations without initials
- An incomplete form or any attempt to change its provisions

INFORMATION ABOUT HEALTH CARE ENHANCEMENT FOR LOCAL PUBLIC SAFETY (HELPS)

The Pension Protection Act of 2006 allows retired or permanently disabled public safety officers (defined below) to elect an amount to be deducted from their TMRS benefit payment to pay for health or long-term care premiums in order to reduce their taxable income. The health insurance or long-term care insurance can include the member, spouse, and dependents. Any amount may be deducted that does not exceed the net monthly annuity. However, the amount that may be excluded from taxable income cannot exceed $3,000 per year. Qualified employees who wish to participate in this deduction program should contact TMRS for an application.

A public safety officer has the same meaning as under Section 1204(9)(A) of the Omnibus Crime Control and Safe Streets Act of 1968, which includes:

- An individual involved in crime and juvenile delinquency control or reduction, or enforcement of the criminal laws (including juvenile delinquency), including, but not limited to police, corrections, probation, parole, and judicial officers
- Professional firefighters
- Officially recognized or designated:
  - Public employee members of a rescue squad or ambulance crew
  - Chaplains or fire departments and police departments

City Statement of Occupational Disability

TMRS®
Texas Municipal Retirement System

A copy of this completed form MUST be attached to the Member and Physician statements.

MEMBER INFORMATION • *Please type or use only black ink and do not highlight. Any corrections must be initialed.*

Member's Name (first, middle, last) _____ Social Security Number _____

Mailing Address _____ Daytime Phone Number _____

City _____ State _____ Zip _____ Employing City _____

JOB DESCRIPTION • *Provide a brief statement of job description and job duties and also* ***attach a photocopy of the employee's job description.***

_____

_____

_____

DESCRIPTION OF ACTIVITIES CUSTOMARILY REQUIRED FOR THIS POSITION

Include information regarding the following: ***how often*** *(never, occasionally, or frequently), and for* ***how long*** *at a time, does the position require:*

	Frequency	Duration		Frequency	Duration
Lifting or carrying 1-10 lbs.			Driving equipment/vehicles		
Lifting or carrying 11-20 lbs.			Working with machinery		
Lifting or carrying 21-40 lbs.			Climbing ladders, stairs, etc.		
Lifting or carrying more than 40 lbs.			Walking		
Bending or stooping			Standing		
Reaching above shoulder level			Sitting		

Provide any other required activities that would be applicable in determining whether the member is capable of performing the customary duties of this position:

_____

_____

_____

_____

_____

CITY OFFICIAL CERTIFICATION

I hereby certify that the information provided above is complete and accurate and that I am duly authorized by the City to complete this form.

Signature of City Official _____ Date Signed (MM/DD/YYYY) _____

Printed Name and Title _____ City Name _____

Please read the instructions provided with this form.

NOTES TO CITY CORRESPONDENT

- If a member of TMRS becomes disabled, he or she may be entitled to regular disability or occupational disability — depending upon the benefit plan adopted by the employing city.
- The test for occupational disability is a finding by the TMRS Medical Board that
  - The member is physically or mentally disabled for further performance of the duties of his/her occupation;
  - The disability is likely to be permanent; and
  - The member should be retired.
- The City Statement for Occupational Disability form must be completed by the member's employing city and should be attached to a photocopy of the member's job description.
- A photocopy of the completed City Statement for Occupational Disability form must be attached to both the Member's Statement for Occupational Disability form and the Physician's Statement for Occupational Disability form.

THE APPLICATION PROCESS

- The retirement date must be the last day of the calendar month, cannot precede the date the member terminates employment, and cannot be before the date the member files this application. Normally a member must apply for retirement not less than 30 days nor more than 90 days before the retirement date. By signing the application, the member agrees to waive any requirement to file the application at least thirty days before the effective date of retirement.
- The following forms must be completed prior to the application being sent to the TMRS Medical Board for consideration:
  - Application for Occupational Disability Retirement — to be completed by the member and certified by the member's employing city
  - City Statement for Occupational Disability — to be completed by the member's employing city
  - Member's Statement for Occupational Disability — to be completed by the member
  - Physician's Statement for Occupational Disability — to be completed by the member's attending physician
  - A photocopy of the member's official job description
- The following forms must completed before TMRS issues your first payment:
  - Selection of Retirement Plan
  - The member's proof of birth (photocopy)
  - Proof of birth for the designated beneficiary — only if a Retiree Lifetime with Survivor Benefits option is selected.

    NOTE: *If the birth name on the proof of birth is different from the names provided on the application (for the member or the beneficiary), a Name Certification must be completed (included in this packet)*
  - Electronic Direct Deposit Authorization- Retiring members must have their monthly annuity payments electronically deposited to their financial institutions

IF THE MEMBER IS ELIGIBLE FOR SERVICE RETIREMENT

- It is recommended that members who are eligible for service retirement apply for Service Retirement benefits rather than Occupational Disability Retirement benefits — the benefits are equal, and there are no restrictions placed on the member's earning capacity. An exception to this might be if the disability retirement would cause the member to be eligible for early Medicare or similar benefits. You should contact TMRS for further information.
- Members who are eligible for service retirement are also entitled to receive a Partial Lump Sum Distribution. If a member elects to receive the partial lump-sum distribution, the Selection of Partial Lump Sum Distribution form will also need to be completed and submitted before TMRS issues your first payment.

RETURNING TO WORK

An Occupational Disability retiree may return to work either for the city or some other employer. However, the monthly benefit will be reduced if the retiree is less than age 60 and if the earnings of the retiree plus the disability retirement benefit exceed the member's compensation at the time of retirement. The monthly benefit will not be reduced below the amount of annuity that the member's own contributions would provide. Occupational Disability retirees may be required to submit yearly proof of any amount received as salary, wages or other earnings along with federal tax form(s) W-2 or 1099.

IMPORTANT NOTE: *If the retiree returns to work in a position that is the same type of position when he or she retired, the monthly annuity would be discontinued and the account reinstated (example: a retired patrol officer cannot go back to work as a patrol officer).*

WHEN TO EXPECT PAYMENT

Retirement payments will begin the last day of the month following the effective date of retirement, if the TMRS Medical Board approves the application.

NOTE: *Monthly payments will be electronically deposited to your financial institution.*

TMRS WILL NOT ACCEPT

- Illegible forms
- Alterations without initials
- Incomplete forms or any attempt to change its provisions

Member's Statement for Occupational Disability

MEMBER INFORMATION

Please type or use only black ink and do not highlight. Any corrections must be initialed.

Member's Name (first, middle, last) _____ Social Security Number _____

Mailing Address _____ Daytime Phone Number _____

City _____ State _____ Zip _____ Employing City _____

Do not complete this form if a copy of the city statement is not attached.

DISABILITY INFORMATION • *You may attach additional pages if necessary to answer any question below.*

1. Describe fully your present disability and its causes with a complete history to date (attach additional pages if necessary):

   _____

   _____

2. Date of injury or beginning of illness leading up to disability: _____
3. Date of leaving job due to disability: _____
4. Employing city and department at the time of disability: _____
5. Does the information furnished by the City on the **attached form TMRS-40/OA** (*City Statement for Occupational Disability*) correctly state your job description, duties, and activities? ☐ yes ☐ no ***(check one)*** If no, please state any matters on which you disagree:

   _____

   _____

6. Which of the duties and/or activities listed on the **attached form TMRS-40/OA** (*City Statement for Occupational Disability*) do you believe you cannot perform?

   _____

7. Is your condition getting worse, is it stable, or is it improving? Please explain:

   _____

   _____

8. List all physicians who have attended you during your present disability (attach additional pages if necessary):

Physician's Name	**Address**	**Dates Attended**

9. Have you received any treatment at a hospital or clinic since the beginning of the disability? ☐ yes ☐ no ***(check one)***
   If yes, please provide the name(s) of the institutions and dates treated:

Institution Name	**Dates Treated**

MEMBER CERTIFICATION

I hereby certify that I am a member of the Texas Municipal Retirement System; that I waive all provisions of law binding any physician or other person who has attended or examined me from disclosing any knowledge or information which he/she thereby acquired; that I hereby consent to an authorized and full disclosure to the Texas Municipal Retirement System of any such knowledge or information; that the above statements were made by me, that they were each and all complete and true to the best of my information, knowledge, and belief, and that they are made for the purpose of securing disability retirement benefits from the Texas Municipal Retirement System.

Member's Signature _____ Date Signed (MM/DD/YYYY) _____

Please read the instructions provided with this form.

THE APPLICATION PROCESS

- The retirement date must be the last day of the calendar month, cannot precede the date you terminate employment, and cannot precede the date you file this application. Normally a member must apply for retirement not less than 30 days nor more than 90 days before the retirement date. By signing this application, you agree to waive any requirement to file the application at least 30 days before the effective date of your retirement.

- Your employing city may have specific requirements for you to notify them of your retirement. Notifying your city and applying to TMRS for retirement are two separate processes. Please coordinate your retirement with your city personnel office to ensure you have met the city's requirements.

- You must complete the following forms prior to the application being sent to the TMRS Medical Board for consideration:
  - Application for Occupational Disability Retirement • to be completed by you and certified by your employer
  - City Statement for Occupational Disability • to be completed by your employer
  - Member's Statement for Occupational Disability • to be completed by you
  - Physician's Statement for Occupational Disability • to be completed by your attending physician
  - A photocopy of your official job description

- You must complete the following forms before TMRS issues your first payment:
  - Selection of Retirement Plan
  - Your proof of birth (photocopy)
  - Proof of birth for your designated beneficiary — only if you choose one of the Retiree Life with Survivor Benefits options
    NOTE: *If the birth name on the proof of birth is different from the names provided on your application (for you or your beneficiary), a Name Certification will need to be completed (included in this packet)*
  - Electronic Direct Deposit Authorization — Retiring members must have their monthly annuity payments electronically
  - deposited to their financial institutions

IF YOU ARE ELIGIBLE FOR SERVICE RETIREMENT

- In many cases, you should consider applying for Service Retirement rather than Occupational Disability. The benefits are equal, and Service Retirement places no restrictions on your earnings. An exception to this might occur if disability retirement would help your eligibility for early Medicare or similar benefits. You should contact TMRS for further information.

- You may choose to receive a Partial Lump Sum Distribution if you are eligible for a service retirement. If you choose to receive a Partial Lump Sum Distribution, you must also complete the Selection of Partial Lump Sum Distribution form and submit the form before TMRS issues your first payment.

RETURNING TO WORK

An Occupational Disability retiree may return to work either for the city or some other employer. However, your monthly benefit will be reduced if you are less than age 60 and if your earnings after retirement plus the disability retirement benefit exceed your compensation at the time of retirement. The monthly benefit will not be reduced below the amount of annuity that your own contributions would provide. Occupational Disability retirees may be required to submit yearly proof of any money received as salary, wages or other earnings along with federal tax form(s) W-2 or 1099.

IMPORTANT NOTE: *If you return to work in a position that is the same type of position you held when you retired, your monthly annuity will be discontinued and your account reinstated (example: a retired patrol officer cannot go back to work as a patrol officer).*

WHEN TO EXPECT PAYMENT

Retirement payments will begin the last day of the month following the effective date of retirement, if the TMRS Medical Board approves your application.

NOTE: *Monthly payments will be electronically deposited to your financial institution.*

TMRS WILL NOT ACCEPT

- Illegible forms. All forms should be typed. Handwritten forms will be accepted only if legible and if completed in black ink
- Alterations without initials
- An incomplete form or any attempt to change its provisions

Physician's Statement for Occupational Disability

TMRS®
Texas Municipal Retirement System

MEMBER INFORMATION

Please type or use only black ink and do not highlight. Any corrections must be initialed.

Member's Name (first, middle, last) _____ Social Security Number _____

Mailing Address _____ Daytime Phone Number _____

City _____ State _____ Zip _____ Member's Employing City _____

Do not complete this form if a copy of the city statement is not attached.

DISABILITY INFORMATION • *You may attach additional pages if necessary to answer any question below.*

1. Provide your diagnosis of physical or mental disability (attach second sheet if necessary):

   _____

   _____

2. Date of onset: _____ Date of first visit for condition leading to disability: _____

   Date of last examination: _____

3. Are you still attending the member? ☐ yes ☐ no ***(check one)***

4. List all other physicians who have attended the member during present disability:

Physician's Name	**Address**	**Dates Attended**

5. Describe the symptoms and physical findings pertinent to your diagnosis (attach copies of any CAT scans, MRI studies, or other pertinent reports):

   _____

   _____

6. From present indications, what seems to be the most probable course of this patient's illness?

   _____

   _____

7. Please review the **attached *City Statement for Occupational Disability* form** (TMRS-40/OA).

   Can the above named member perform all duties and activities of the job as described on the *City Statement for Occupational Disability* form (TMRS-40/OA)? ☐ yes ☐ no ***(check one)***

   If no, please list those activities described on the *City Statement for Occupational Disability* form (TMRS-40/OA) which, in your opinion, the member cannot perform due to the physical or mental disability described (attach second sheet if necessary):

Activity	**Frequency**	**Duration**

PHYSICIAN INFORMATION

Physician's Name *(printed or typed)* _____

Physician's Mailing Address _____

Physician's Signature _____ Date Signed (MM/DD/YYYY) _____

Please read the instructions provided with this form.

NOTES TO PHYSICIAN

- All medical information you submit is for interpretation by actively practicing physicians to determine the member's disability status according to the laws governing the Texas Municipal Retirement System. The System needs the answers to all of the questions. Copies of a current history and physical, hospital discharge summary, narrative report or comprehensive consultation, or other pertinent information, may also provide helpful information to supplement specific answers to questions on the form.

- The City Statement for Occupational Disability **MUST BE ATTACHED** in order to complete the Physician's Statement. If the City Statement is not provided, please contact TMRS or your patient.

TMRS WILL NOT ACCEPT

- Illegible forms. All forms should be typed. Handwritten forms will be accepted only if legible and if completed in black ink
- Alterations without initials
- An incomplete form or any attempt to change its provisions

Selection of Retirement Plan

MEMBER INFORMATION • *Please type or use only black ink and do not highlight. Any corrections must be initialed.*

TMRS® Texas Municipal Retirement System

Member's Name (first, middle, last) _____ Social Security Number _____

Mailing Address _____ Daytime Phone Number _____

City _____ State _____ Zip _____ City Number _____

MARITAL STATUS *(must check one):* ☐ Married ☐ Not married
(If married, see Spousal Consent section below)

TMRS Identification Number (not required) _____

BENEFICIARY DESIGNATION (LIMIT 3) *Please read instructions carefully. If desired, alternate beneficiary designations may be completed on page 2.*

Beneficiary's Full Name (first, middle, last) _____ Social Security Number _____

Sex: ☐ Male ☐ Female Relationship (required) _____ Date of Birth (MM/DD/YYYY) _____

Beneficiary's Full Name (first, middle, last) _____ Social Security Number _____

Sex: ☐ Male ☐ Female Relationship (required) _____ Date of Birth (MM/DD/YYYY) _____

Beneficiary's Full Name (first, middle, last) _____ Social Security Number _____

Sex: ☐ Male ☐ Female Relationship (required) _____ Date of Birth (MM/DD/YYYY) _____

CUSTODIAN UNDER THE TEXAS UNIFORM TRANSFERS TO MINORS ACT

You may designate a custodian if any beneficiary is under 21 years of age.

Custodian's Name (first, middle, last) _____ Custodian's Relationship to Beneficiary _____

RETIREMENT OPTIONS

Please read instructions before completing, and ***check only one box.***

Retiree Life Only Benefit *(up to 3 beneficiaries)*
☐

Retiree Life – Survivor Benefits *(only 1 beneficiary)*
☐ 100% ☐ 75% ☐ 50%

Retiree Life – Guaranteed Term Benefits *(up to 3 beneficiaries)*
☐ 5 yr ☐ 10 yr ☐ 15 yr

MEMBER SIGNATURE REQUIRED

This beneficiary designation revokes all previous beneficiary designations and will control for all purposes, even if retirement does not become effective. I request that, should I die, my retirement benefits and any Supplemental Death Benefits that may be due be paid as I have designated on this form. I understand that if my designated beneficiary(ies) or I should die before recovering the amount of accumulated deposits and interest in my individual account at the time of retirement, the remaining balance will be paid to my estate or beneficiary. I further understand that if I elect to receive a partial lump sum distribution at retirement, my remaining balance will be reduced by the same dollar amount. By signing this form, I certify that I have read the attached instructions and that my marital status is as indicated above.

Member's Signature _____ Date Signed (MM/DD/YYYY) _____

SPOUSAL CONSENT (NOTARIZATION REQUIRED)

Your spouse must complete this section if your spouse is not your only primary beneficiary or you have named someone other than your spouse as beneficiary, or if you have named your spouse and have not selected one of the Retiree Life-Survivor Benefits (100%, 75%, or 50%) options above. I understand that I may require my spouse to name me as beneficiary under a Survivor Life benefit. Nevertheless, I hereby consent to the beneficiary(ies) designated and the retirement option selected.

Spouse's Signature _____ Date Signed (MM/DD/YYYY) _____

The State of Texas County of _____

This instrument was acknowledged before me on the _____ day of _____, 20_____, by _____.
(Name of Spouse)

(SEAL)

_____
Notary Public, State of Texas

Please read the instructions provided with this form.

DESIGNATING BENEFICIARIES

- Your beneficiary designation is effective immediately and revokes all previous beneficiary designations even if your retirement does not become effective. The number of beneficiaries you can designate will depend on the retirement option you select.
- Retiree Life - Survivor Benefits: ONLY 1 beneficiary may be designated and you cannot change your beneficiary after your effective retirement date (unless your beneficiary dies before you and you remarry— please call TMRS directly for more information).
- Retiree Life Only and Retiree Life - Guaranteed Term Benefits: 1 – 3 beneficiaries or an Estate may be designated and you can change your beneficiary designation at any time.
- You may designate up to three primary beneficiaries and up to three alternate beneficiaries if you have selected either the Retiree Life Only Benefit or one of the Retiree Life - Guaranteed Term Benefits. Unless otherwise directed in writing on this form, your benefits will be paid equally to the surviving primary beneficiaries, or equally to the surviving alternate beneficiaries if there are no surviving primary beneficiaries. Contact TMRS for instructions on how to provide for unequal distributions.
- If you want to designate alternate beneficiaries, you must complete pages 1 and 2 of this form and submit both pages to our system. Your benefits will be paid to your alternate beneficiary only if your designation with respect to each primary beneficiary is revoked by death or if your relationship to each primary beneficiary terminates.

SUPPLEMENTAL DEATH BENEFITS (SDB)

- If your employer provides Supplemental Death Benefits (SDB) for retirees, at the time of your death, TMRS will pay a one-time lump sum payment of $7,500. The SDB payment will be paid to the beneficiary(ies) designated on this form, even if you have previously designated a different SDB beneficiary.
- If you wish to designate a beneficiary other than the person(s) listed on this form to receive the SDB payment, you will need to complete the Supplemental Death Benefit Beneficiary Designation form.

ESTATE, TRUST, & CHARITY DESIGNATIONS

- If you wish to designate your Estate as beneficiary, please write only the word "ESTATE" in the space provided for the name of the beneficiary.
- If you wish to designate a Charity as beneficiary, please write the name of the charity (i.e., American Heart Association) in the space provided for the name of the beneficiary.
- If you wish to designate a Trust, please write "Trustee of the (enter name of trust here)" in the space provided for the name of the beneficiary. Please ensure that you have a legal trust agreement in place prior to designating a "Trust" on this form.
    - TMRS will accept the designation of a Trust. However, we cannot assure that if and when a benefit becomes payable from this System, the designation will be legally valid. In other words, if the trustee does not accept or has died, or if the Trust has been revoked, or if for any other reason the designation is not legally sufficient at the time of the member's death, the benefit due from the System will be paid in accordance with the provisions of the TMRS Act as if no trust/trustee had been designated.
    - A Trust having more than one beneficiary may not receive benefits to which multiple designated beneficiaries are not eligible. A Trust that may be revoked is not a "designated beneficiary" under the Internal Revenue Code, and may not receive retirement system benefit payments for a period longer than five (5) years.

DESIGNATING MINOR CHILDREN (CUSTODIAN UNDER TUTMA)

Chapter 141 of the Texas Property Code is the Texas Uniform Transfers to Minors Act (TUTMA), which allows you to nominate a "custodian" to receive TMRS benefits on behalf of your minor beneficiary. If you wish to designate a minor child, please do the following:

- Write the full name and all information pertaining to the minor child in the "Primary Beneficiary" or "Alternate Beneficiary" section of the form. Then complete the "Custodian Section" directly under the beneficiary section.

RULES

- Only adults at least 21 years of age, financial institutions, corporations, or other legal entities may serve as custodians.
- You cannot nominate two or more custodians to serve jointly. However, you may designate a substitute custodian to serve in the event the first designated custodian dies before the first payment is made, declines, or is ineligible to serve. Please contact TMRS for instructions on how to nominate a substitute custodian.
- You may designate the same custodian for up to three minors. If one custodian is named for all three minors, that custodian would receive separate benefit payments for each minor.
- When the minor beneficiary reaches age 21, the custodianship for that beneficiary as to TMRS benefits is automatically terminated and any benefits that become payable will be paid directly to that beneficiary.
- The designated custodian can select any benefit option that the minor could select if the minor were an adult.
- If an eligible custodian is designated to receive benefits, there is no limit on the amount that can be paid to the custodian.
- The minor's Social Security number is used for IRS reporting purposes.

Alternate Beneficiary Section (optional)

MEMBER INFORMATION *Please type or use only black ink and do not highlight. Any corrections must be initialed.*

Member's Name (first, middle, last) _____ Social Security Number _____

DESIGNATING AN ALTERNATE BENEFICIARY (LIMIT 3) *Please read instructions before completing. Unless otherwise specified, benefits will be divided equally among surviving alternate beneficiaries, only if the designation with respect to each primary beneficiary designated on page 1 of this form is revoked by death or if your relationship with each primary beneficiary has terminated.*

Beneficiary's Full Name (first, middle, last) _____ Social Security Number _____

Sex: ☐ Male ☐ Female Relationship (required) _____ Date of Birth (MM/DD/YYYY) _____

Beneficiary's Full Name (first, middle, last) _____ Social Security Number _____

Sex: ☐ Male ☐ Female Relationship (required) _____ Date of Birth (MM/DD/YYYY) _____

Beneficiary's Full Name (first, middle, last) _____ Social Security Number _____

Sex: ☐ Male ☐ Female Relationship (required) _____ Date of Birth (MM/DD/YYYY) _____

CUSTODIAN UNDER THE TEXAS UNIFORM TRANSFERS TO MINORS ACT

You may designate a custodian if any beneficiary is under 21 years of age. See attached instructions.

Custodian's Name (first, middle, last) _____ Custodian's Relationship to Beneficiary _____

MEMBER SIGNATURE REQUIRED

If you complete any part of page 2, your signature is required on both pages 1 and 2.

By signing this form, I certify that I have read the attached instructions. I understand that death benefits will only be paid to the alternate beneficiary(ies) listed above in the event I am not survived by any primary beneficiary(ies) designated on page 1 of this form or my relationship with each primary beneficiary has terminated.

Member's Signature _____ Date Signed (MM/DD/YYYY) _____

SPECIAL INSTRUCTION: Completion of this section is optional. If completed, page 2 must accompany page 1 when submitted to our system.

EXPLAINING YOUR RETIREMENT OPTIONS

RETIREE LIFE ONLY BENEFIT

A retirement benefit payable monthly as long as you live. However, upon your death all payments will cease even though you may have received only one monthly payment.*

RETIREE LIFE – SURVIVOR BENEFITS

100% A retirement benefit payable monthly as long as you live. At your death, your beneficiary will receive 100% (the full amount) of the monthly benefit for as long as he or she lives. If your beneficiary dies before you, the monthly payments you receive after that will be increased to the amount that would have been payable as a Retiree Life Only Benefit. *

75% A retirement benefit payable monthly as long as you live. At your death, your beneficiary will receive 75% (three-fourths) of the monthly annuity for as long as he or she lives. If your beneficiary dies before you, the monthly payments you receive after that will be increased to the amount that would have been payable as a Retiree Life Only Benefit. *

50% A retirement benefit payable monthly as long as you live. At your death, your beneficiary will receive 50% (one-half) of the monthly annuity for as long as he or she lives. If your beneficiary dies before you, the monthly payments you receive after that will be increased to the amount that would have been payable as a Retiree Life Only Benefit. *

RETIREE LIFE – GUARANTEED TERM BENEFITS

5 yr A retirement benefit payable monthly as long as you live. However, should you die before the expiration of a 5-year period after the date of retirement, your designated beneficiary will receive the same benefit for the balance of the 5-year period, and then all payments cease.*

10 yr A retirement benefit payable monthly as long as you live. However, should you die before the expiration of a 10-year period after the date of retirement, your designated beneficiary will receive the same monthly benefit for the balance of the 10-year period, then all payments cease.*

15 yr A retirement benefit payable monthly as long as you live. However, should you die before the expiration of a 15-year period after the date of retirement, your designated beneficiary will receive the same monthly benefit for the balance of the 15-year period, then all payments cease.*

* **If you and your designated beneficiary, die prior to having recovered the amount of accumulated contributions and interest in your individual account at the time of retirement, the remaining balance will be paid to your estate or beneficiary. If you elect to receive a partial lump sum distribution on the effective date of your retirement, your remaining balance will be reduced by the same dollar amount.**

TMRS WILL NOT ACCEPT:

- Attachments (listing additional beneficiaries)
- Alterations without initials
- An incomplete form or any attempt to change its provisions
- An unacceptable designation

Acceptable Proofs of Birth

Purpose:

Date of birth must be verified before payment of any monthly annuity can be made. Date of birth may be established by providing an **unaltered photocopy** of any one of the documents listed below.

- **Texas Drivers License or Texas Identification Card**
- **Official Certificate of Birth** issued by the state in which the birth occurred. Consult the County Clerk for necessary forms and instructions. No hospital issued certificates.
- **Delayed Certificate of Birth** issued by the state in which the birth occurred. Consult the County Clerk for necessary forms and instructions.
- **Bureau of Census Transcript** from Dallas, Texas, 214.640.4470, stating the age of the individual at the time a census was registered.
- **Baptismal or Parish Record** indicating the age of the individual at the time of baptism. Please complete a Baptismal or Parish Record Affidavit if this form of proof of birth is submitted (contact TMRS at 800.924.8677.
- **Family Bible Record** indicating the birth date of the individual. Please complete a Family Bible Record Affidavit if this form of proof of birth is submitted (contact TMRS at 800.924.8677).
- **Naturalization/Immigration Certificate** indicating the age of the individual.
- **Armed Forces Discharge Papers (DD214 or equivalent)**.
- **Signed letter from Social Security Administration** indicating the date of birth of the individual, which has been accepted by Social Security Administration.
- **Passport.**
- **School Record.**
- **Insurance Policy** (must be at least 10 years old).
- **Marriage License** indicating either date of birth or age at time of marriage of individual.
- **Child's Birth Certificate** indicating age of parent (individual whose date of birth is being certified).

Name Certification

If the name provided on the proof of birth is different from the name on TMRS records, a Name Certification (TMRS-30) must be completed by the member or beneficiary that certifies the two names are the same person.

Name Certification

MEMBER INFORMATION

Please type or use only black ink and do not highlight. Any corrections must be initialed.

TMRS Identification Number (not required)

Member's Name (first, middle, last)

Social Security Number

Mailing Address

Daytime Phone Number

City

State

Zip

City Name (required)

City Number

PURPOSE

The purpose of this Name Certification is to certify that even though names may differ on plan records, the person is one and the same. Completion of this form is mandatory **only** if the name(s) on the proof of birth is different from the name(s) on TMRS records.

I, _____, hereby certify and do solemnly swear that I am
(Affiant's name as indicated on TMRS record)

_____, and my true and correct date of birth is _____.
(Affiant's name as indicated on proof of birth) (MM/DD/YYYY)

Affiant's Signature

Date Signed (MM/DD/YYYY)

NOTARIZATION REQUIRED

The State of Texas County of _____

Before me on this day personally appeared _____, known to me to be the person who signed the above Name Certification and declared to me upon oath that the statement therein contained are true and correct. Given under my hand and seal of office this _____day of _____, 20_____.

(SEAL)

Notary Public, State of Texas

NOTICE TO PERSONS SIGNING THIS AFFIDAVIT

Section 851.101 of the Texas Government Code provides for punishment by fine and/or imprisonment of (i) a person who knowingly makes a false statement in a report or application to the retirement system in an attempt to defraud the system or (ii) a person who knowingly makes a false certificate of an official report to the retirement system.

Direct Deposit Authorization

CAUTION: This form cannot be used to authorize the direct deposit of your benefit payments into a trust account. If you want to do that, please contact TMRS Member Services for additional information and appropriate form.

TMRS®
Texas Municipal Retirement System

PERSONAL DATA

Please type or use only black ink and do not highlight. Mail or fax completed form to TMRS.

Name (first, middle, last) _____ Social Security Number _____

Mailing Address _____ Date of Birth (MM/DD/YYYY) _____

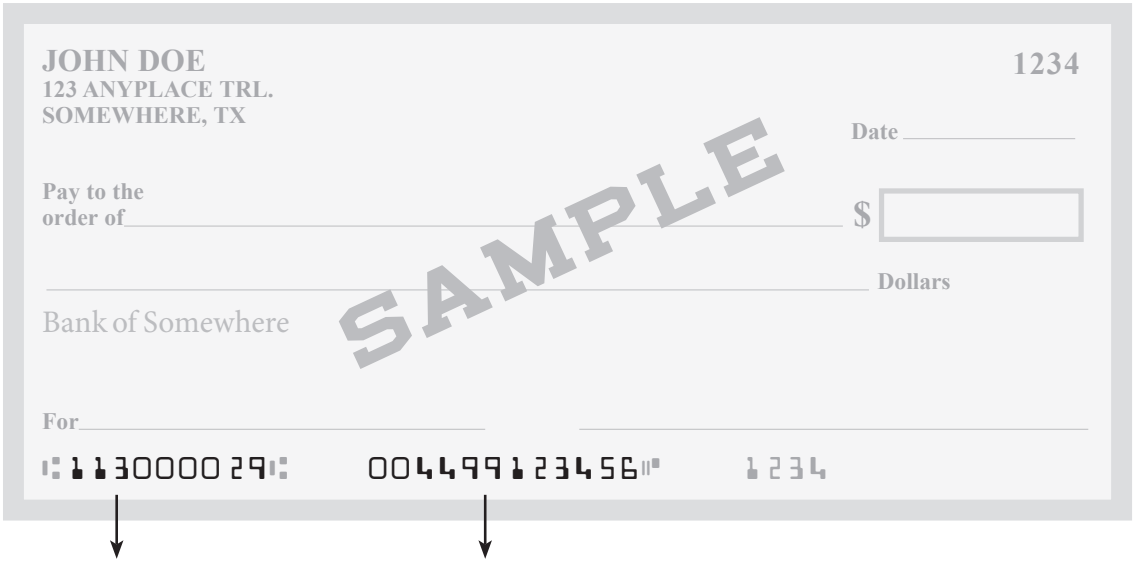
City _____ State _____ Zip _____ Daytime Phone Number _____

E-mail Address _____ TMRS Identification Number (not required) _____

FINANCIAL INSTITUTION DATA

Financial Institution Name _____ Financial Institution Phone Number _____

To ensure accuracy, please tape a voided check here *(no deposit slips)*.



Important Information About Direct Deposit

- **ACCOUNT CHANGES** If you change your account or account number, you must file another direct deposit authorization.
- **FUND AVAILABILITY** Generally, your money will be deposited to your account and available by the last business day of the month.

Routing Number (first nine digits) _____ Payee Account Number _____ Individual's Name(s) on Financial Account* _____

***Note:** If you are not an account holder on this account, we cannot process your request for direct deposit.

Type of Account: ☐ *Checking* ☐ *Savings*

PAYEE'S AUTHORIZATION

I authorize the Texas Municipal Retirement System (TMRS) to deposit my monthly retirement benefit electronically to the financial institution and the account indicated above. I also authorize TMRS and the Financial Institution to correct any credit entries made in error.

Payee's Signature _____ Date (MM/DD/YYYY) _____