SCHOOL EMPLOYEES RETIREMENT SYSTEM OF OHIO

300 E. BROAD ST., SUITE 100 • COLUMBUS, OHIO 43215-3746
614-222-5853 • Toll-Free 800-878-5853 • www.ohsers.org

SERVICE RETIREMENT APPLICATION

This application must be typed or completed in ink and the original returned to SERS. See the SERS Service Retirement Guide for instructions on completing the application. All sections of this form must be completed before SERS can begin paying your retirement benefits.

Personal Information

Social Security Number: ☐☐☐-☐☐-☐☐☐☐ Date of Birth: _____

Your Name: _____
FIRST MIDDLE (MAIDEN) LAST

Address: _____ County:_____
STREET OR ROUTE NUMBER OR P.O. BOX

_____Email Address: _____
CITY STATE ZIP

Home Telephone Number: (_____) _____ Cell Phone Number: (_____)_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

If Married, Spouse's Name: _____ Spouse's Sex: ☐ M ☐ F

Spouse's Social Security Number: ☐☐☐-☐☐-☐☐☐☐ Spouse's Birth Date: _____

☐ Please check this box if you are **not** a U.S. citizen

Retirement Information

My last service was, or will be, completed: month _____ year_____

I wish to apply for service retirement effective: month _____ year_____

☐ Check here if you are retiring as a public safety officer.

Are you a member of or receiving a benefit from (mark those that apply):

	MEMBER	RECEIVING A BENEFIT
State Teachers Retirement System of Ohio (STRS)	☐	☐
Ohio Public Employees Retirement System (OPERS)	☐	☐
Ohio Police & Fire Pension Fund (OP&F)	☐	☐
State Highway Patrol Retirement System (SHPRS)	☐	☐

Do you wish to combine your account with the above system(s)? ☐ No ☐ Yes

If you are currently working in more than one position covered by SERS, OPERS, or STRS, are you continuing to work in the lower-paying position? ☐ No ☐ Yes

Which system covers the lower-paying position? ☐ SERS ☐ OPERS ☐ STRS

Have you ever received Workers' Compensation in lieu of salary for a job-connected injury in Ohio schools?

☐ No ☐ Yes

☐ Check here if you are going to be reemployed in an Ohio public job within the first two months after retirement.

If so, date of employment_____ Employer: _____

Payment Plan Choice - Check Only One and List Your Beneficiary

Selection of any plan will provide a monthly benefit to you for your life. After your death, a monthly benefit for your beneficiary for his or her life is available only under Plans A, C, D, or F. Under the current standards, continuation of health care coverage to the spouse is available through these plans. Regardless of the payment plan choice, a $1,000 death benefit will be paid to your designated beneficiary. If you have multiple beneficiaries, this will be distributed equally among them.

Your Beneficiary: (Must Be Completed for Plans A, B, C, or D)

BENEFICIARY NAME (FIRST, MIDDLE, LAST) SEX RELATIONSHIP DATE OF BIRTH

BENEFICIARY SOCIAL SECURITY NUMBER STREET ADDRESS CITY STATE ZIP

☐ **Plan A - Joint Life - One-Half to Spouse**

Half your gross monthly pension will be paid to your spouse upon your death. Once your spouse becomes the recipient, payment to your spouse is for his or her lifetime. A copy of your birth certificate, your spouse's birth certificate, and your marriage certificate is required.

☐ **Plan B - Single Life Allowance - No Monthly Payment to Beneficiary**

This plan pays the highest amount to you, but ceases with your death. If all member contributions have not been recovered in the form of monthly benefits, the remainder is paid in a lump sum to the designated beneficiary. If you designate multiple beneficiaries, any amount will be distributed equally among them. A copy of your birth certificate is required.

☐ **Plan C - Joint Life - Designated Amount to Beneficiary**

You can designate a set percentage or amount for your beneficiary for his or her life. This cannot exceed whatever you received; but, if an amount is designated, the minimum must be $100 a month. Federal tax law may require a different minimum amount if you name someone other than your spouse as beneficiary. Contact SERS for more information on the minimum amount required. A copy of your and your beneficiary's birth certificate is required.

If this plan is selected, state the amount payable to your beneficiary after your death:
$_____ **OR** percentage_____%.

☐ **Plan D - Joint Life - Same Amount to Beneficiary**

Plan D provides the same gross monthly amount to your beneficiary that you were drawing at the time of your death. Due to federal tax law, if there is too great a difference in the ages between you and your beneficiary other than a spouse, this plan may not be available.

☐ **Plan E - Guaranteed Allowance**

You may guarantee beneficiary protection for a limited period of time under Plan E. Several options are available as to the period of time - 5 years, 10 years, 15 years and other periods are available upon request. The gross monthly amount to your beneficiary is the same as you were receiving at the time of your death. Beneficiary protection is guaranteed, however, only for the period of time chosen, and begins with your effective date of retirement. If you designate multiple beneficiaries, the amount payable is the remaining annuity discounted to its present value and will be paid in a one-time lump sum equally among them. Please refer to your Service Retirement Guide. If you select this plan you will be sent a separate form for designation of beneficiaries. This form must be received by SERS before benefits are paid. This plan cannot be changed under any circumstances. A copy of your birth certificate is required.
Number of years of guaranteed beneficiary protection _____.

☐ **Plan F - Joint Life – Multiple Beneficiaries**

You may name up to four persons to receive monthly benefits upon your death. Each additional beneficiary named will reduce your own pension. You must designate a percentage of your monthly pension OR a flat dollar amount for each beneficiary. The amount designated cannot be less than 10% unless required by a court order, and the amount for all beneficiaries cannot exceed 100%. If you are required by a court order to provide a benefit for an ex-spouse, include a copy of the court order. If you select this plan, you will be sent a separate form for designation of beneficiaries. This form must be received by SERS before pension benefits are paid. A copy your birth certificate and your spouse's birth certificate is required.

Document Requirement List

Please send the following information with your application to SERS; these documents are required to process your Retirement Application. Please make sure your current name is written on the document copies.

- Birth Certificates (copies only)

  Yourself

  Spouse (for Joint Survivor plans A, C, D, or F and/or health care coverage)

  Non-Spouse beneficiary (for Joint Survivor plans C, D, or F)

  Spouse and dependents covered by SERS' Health Care

- Copy of your marriage certificate, if you are married.
- A complete copy of your divorce decree including any separation agreement, if your current marital status is divorced.
- Direct Deposit Form
- Health Care Application
- Partial Lump Sum Application
- Spousal Consent Form
- Copy of Medicare Card

  Yourself

  Spouse

Member's Signature (Required)

I certify that:

1. I am applying for service retirement with SERS;
2. The information that I have supplied in this application is accurate and true; and
3. I authorize the deduction of health care coverage premiums, if applicable.

_____ _____

SIGNATURE (REQUIRED) DATE

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PARTIAL LUMP SUM OPTION PAYMENT (PLOP)

Your Name: _____

In addition to your monthly pension, you may take part of your pension in a one-time partial lump sum option (PLOP) which will reduce your lifetime monthly pension permanently. The PLOP amount may be from a minimum of 6 months up to a maximum of 36 months of your unreduced allowance, but it cannot reduce your original allowance by more than 50%. Once you receive your PLOP amount, you cannot change your PLOP or payment plan.

☐ I **do not** wish to take a PLOP.

If you want to select a PLOP **mark only one of the boxes below**. If you are married, your spouse must complete the Spousal Consent at the end of this application.

☐ I select the minimum amount of 6 times my unreduced monthly pension amount.

OR

☐ I select the maximum amount of 36 times my unreduced monthly pension amount.

OR

☐ I select the following number of whole months (between 7 and 35) of my unreduced monthly pension amount: _____ months.

OR

☐ I want to receive the following amount of: $ _____. If this amount exceeds the maximum number of months allowable, your payment is adjusted to the maximum PLOP amount. If it is below the minimum number of months allowable, your payment is adjusted to the minimum PLOP amount.

If the total amount of the PLOP includes a taxable portion, SERS is required to withhold 20% of the taxable amount for federal income tax withholding. You may be able to continue to defer federal taxation by making an eligible rollover. Retirees under the age of 59-1/2 may also be subject to an additional 10% federal tax unless the PLOP is rolled over.

Do you want to roll over any portion of the PLOP? ☐ Yes ☐ No

If you marked "Yes," SERS will send you additional information on your options and a form.
If you marked "No," the amount will be sent to you.

Member's Signature (Required)

I certify that:

1. I am applying for service retirement with SERS;
2. The information that I have supplied in this application is accurate and true; and
3. I authorize the deduction of health care coverage premiums, if applicable.

_____ _____
SIGNATURE (REQUIRED) DATE

If you are married, your spouse must complete a Spousal Consent.

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SPOUSAL CONSENT

Fill Out and Sign in Ink - See Service Retirement Guide for Instructions

Name: _____

To retiring member: If you are married, and you did not select Plan A with your spouse as the beneficiary, and/or you selected a PLOP, your spouse must **sign** the consent section in the presence of a notary public or SERS counselor. If your spouse does not consent, SERS will be required to pay your retirement under Plan A. Your spouse does not have to sign if you are under a court order to select a payment plan naming your ex-spouse as a beneficiary and choose Plan F designating only your ex-spouse and current spouse as beneficiaries. If your spouse is medically incapable of providing consent or the spouse's whereabouts are unknown, contact SERS.

Payment Plan Selected: _____

PLOP Amount: _____

I, _____, certify that I have:
NAME OF SPOUSE

1. Read and I understand the payment plans described in this application and my spouse's selection;
2. Reviewed and I understand my spouse's selection of a beneficiary or beneficiaries in this application;
3. Reviewed and I understand my spouse's selection of a PLOP, if chosen, in this application; and
4. Consent to these selections.

_____
SPOUSE'S SIGNATURE (DO NOT PRINT)

_____
DATE

Witnessed by: _____ _____
SERS Counselor in Columbus office DATE

OR

State of _____)
) ss.
County of _____)

Sworn before me and subscribed this _____ day of _____, 20_____.

_____
NOTARY PUBLIC

_____
MY COMMISSION EXPIRES

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HEALTH CARE APPLICATION / WAIVER

Your Name: _____ Social Security Number: _____

If You Do Not Complete Section A or B, You Will Be Automatically Enrolled in a Health Care Plan.

A. WAIVER OF HEALTH CARE

If you do not want to enroll in SERS' health care coverage, please read and sign this section.

I hereby waive any medical and prescription drug coverage provided by SERS. I also understand that I forfeit my Medicare Part B reimbursement. I understand that my waiver is effective during my lifetime for me, my spouse, and my eligible children, and can only be revoked:

- Within 90 days of becoming eligible for Medicare, or
- Within 31 days of the involuntary termination of coverage under another plan or termination of Medicaid.

Your signature _____ Date _____

IF YOU SIGNED THE WAIVER, GO DIRECTLY TO SECTION D – DO NOT COMPLETE SECTIONS B or C.

B. ENROLLMENT IN HEALTH CARE

Premiums for you, your spouse, and/or children will be deducted from your monthly payment.

1. **Date you want SERS health care coverage to begin:** _____

2. **Plan Selection -** Choose only one of the following health care plans:

Non-Medicare Plans
- ☐ Aetna Choice POS II
- ☐ AultCare PPO
- ☐ Wraparound Plan

Medicare Plans
- ☐ Aetna Medicare℠ Plan (PPO)
- ☐ PrimeTime (Medicare)

3. **Dependent Coverage**
If you are enrolling a spouse or child(ren) in SERS health care coverage, please list them below:

NAME OF DEPENDENT	SOCIAL SECURITY NUMBER	SEX	DATE OF BIRTH	INCAPACITATED?
_____	_____	☐ M ☐ F	_____	☐ Yes ☐ No
_____	_____	☐ M ☐ F	_____	☐ Yes ☐ No

Required Documents – You must provide copies of the Medicare cards or Entitlement Letters for anyone listed above who is or will be enrolled in Medicare. Also, please include copies of birth certificates for anyone listed above.

C. MEDICARE PART B REIMBURSEMENT

Primary benefit recipients enrolled in SERS' health care coverage and Medicare Part B can be reimbursed $45.50 per month to help pay the Medicare Part B premium. The reimbursement continues as long as the benefit recipient is enrolled in SERS' coverage and Medicare Part B. Individuals receiving Medicare Part B at no cost are not entitled to this reimbursement.

Do you (or does your spouse on your behalf) receive Medicare Part B reimbursement from any source, including the Medicare Premium Assistance Program or Medicaid?.....☐ Yes ☐ No

If "yes," name the source of reimbursement _____

Please Complete Sections D, E, and F.

D. ENROLLMENT IN DENTAL AND VISION

1. Dental Plan

You may enroll in the dental plan. Monthly premiums will be deducted from your pension payments. If enrolling dependents, please include copies of birth certificates.

☐ Enroll me only in the dental plan ☐ Do not enroll me in the dental plan
☐ Enroll me and the dependent(s) listed below:

NAME OF DEPENDENT	SOCIAL SECURITY NUMBER	SEX	DATE OF BIRTH	INCAPACITATED?
_____	_____	☐ M ☐ F	_____	☐ Yes ☐ No
_____	_____	☐ M ☐ F	_____	☐ Yes ☐ No

2. Vision Plan

You may enroll in the vision plan. Monthly premiums will be deducted from your pension payments. If enrolling dependents, please include copies of birth certificates.

☐ Enroll me only in the vision plan ☐ Do not enroll me in the vision plan
☐ Enroll me and the dependent(s) listed below:

NAME OF DEPENDENT	SOCIAL SECURITY NUMBER	SEX	DATE OF BIRTH	INCAPACITATED?
_____	_____	☐ M ☐ F	_____	☐ Yes ☐ No
_____	_____	☐ M ☐ F	_____	☐ Yes ☐ No

E. PENSION AND BENEFIT INFORMATION

Are you or your spouse currently enrolled in health care or receiving a pension payment from any other Ohio Retirement Systems?..... ☐ Yes ☐ No

If "yes," check which system and what you are receiving:	HEALTH CARE	PENSION
Ohio Public Employees Retirement System	☐ Self ☐ Spouse	☐ Self ☐ Spouse
State Teachers Retirement System of Ohio	☐ Self ☐ Spouse	☐ Self ☐ Spouse
Ohio Highway Patrol Retirement System	☐ Self ☐ Spouse	☐ Self ☐ Spouse
Ohio Police & Fire Pension Fund	☐ Self ☐ Spouse	☐ Self ☐ Spouse

F. ELIGIBILITY WITH LAST SCHOOL EMPLOYER

Did your school employment end more than 12 months ago? ☐ Yes ☐ No

If you checked **"Yes"**:

1) Were you eligible for your school employer's health coverage at the time you separated from service?.....☐ Yes ☐ No
2) Were you eligible for your school employer's health coverage three of the last five years that you worked?.....☐ Yes ☐ No

REEMPLOYMENT NOTICE: Your eligibility for SERS health care coverage may be affected if you or your spouse go back to work. You will need to notify SERS when you or your spouse are reemployed in a private or public sector position unless you are enrolled in Medicare Part B.

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DIRECT DEPOSIT FORM

Recipient's Name: _____ Social Security Number: _____

Address _____

City _____ State _____ ZIP_____ Phone Number _____

DIRECT DEPOSIT INFORMATION

- Payments can be made to a checking or savings account; choose only **one** account.
- Your name must be on the account.
- Forms received by the 15th of the month will be processed for payment the following month.
- If this form is being signed by a power of attorney (POA) or guardian, the POA or guardianship documents must be on file with SERS. A POA should sign as follows: *Your name,* POA for *Recipient's Name*.

CHOOSE ONE OF THE FOLLOWING:

☐ **CHECKING** ☐ **SAVINGS** - contact your financial institution for the nine-digit routing or transit number.

Name of Financial Institution _____ Phone Number _____

Account No:_____ Nine-digit routing or transit number ☐☐☐☐☐☐☐☐☐

To deposit your payment to a checking account, you must attach either **A VOIDED CHECK PRE-PRINTED WITH YOUR NAME AND ADDRESS** to the section provided on the back page of this form or **A LETTER FROM YOUR BANK CONFIRMING THAT YOU ARE THE OWNER OF THE BANK ACCOUNT AND INCLUDE THE ROUTING AND ACCOUNT NUMBERS**. To deposit your payment to a savings account, you must attach **A LETTER FROM YOUR BANK CONFIRMING THAT YOU ARE THE OWNER OF THE BANK ACCOUNT AND INCLUDE THE ROUTING AND ACCOUNT NUMBERS**.

Forms may be faxed to 614-222-5828.

RECIPIENT'S SIGNATURE

I, the undersigned, authorize SERS to transmit my payments to the above-named financial institution; recover directly from the financial institution any payments electronically deposited to my financial institution to which I am not entitled; and authorize and direct my financial institution on my behalf or on behalf of my estate to refund such benefit overpayments to SERS, and charge it accordingly to my account. I also authorize my financial institution to provide SERS with account information to assist in recovery of such benefit overpayments, including information about any joint account holders and account transactions occurring after my death. I attest that I am an owner of the account.

_____ _____

RECIPIENT'S SIGNATURE (DO NOT PRINT) DATE

FOR DEPOSIT TO A CHECKING ACCOUNT

Tape a voided check here.

SERS does not accept temporary checks or deposit slips.