



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

If Married, Spouse's Name: \_\_\_\_\_ Spouse's Sex:  M  F

Spouse's Social Security Number: -- Spouse's Birth Date: \_\_\_\_\_

### 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)	<input type="checkbox"/>	<input type="checkbox"/>
Ohio Public Employees Retirement System (OPERS)	<input type="checkbox"/>	<input type="checkbox"/>
Ohio Police & Fire Pension Fund (OP&F)	<input type="checkbox"/>	<input type="checkbox"/>
State Highway Patrol Retirement System (SHPRS)	<input type="checkbox"/>	<input type="checkbox"/>

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)

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BENEFICIARY NAME (FIRST, MIDDLE, LAST)	SEX	RELATIONSHIP	DATE OF BIRTH
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BENEFICIARY SOCIAL SECURITY NUMBER	STREET ADDRESS	CITY	STATE	ZIP
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**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.

- 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: \_\_\_\_\_ DATE
SERS Counselor in Columbus office

OR

State of \_\_\_\_\_ )
County of \_\_\_\_\_ ) ss.

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 decide to waive 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 Section, Go Directly To Section C – Do Not Complete Section B.**

### B. HEALTH CARE COVERAGE

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:

- Aetna Medicare<sup>SM</sup> Plan (PPO)     
  Paramount Elite (Medicare)     
  PrimeTime (Medicare)  
 Aetna Choice POS II     
  AultCare PPO     
  Wraparound Plan

#### 3. Dependent Coverage

Do you request health care coverage for your  Spouse or  Child(ren)?

NAME OF DEPENDENT	SOCIAL SECURITY NUMBER	SEX	DATE OF BIRTH	INCAPACITATED?
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

#### 4. Medicare Verification

Please provide copies of Medicare cards or Entitlement Letters if you, your spouse, and/or your children are enrolled in Medicare.

#### 5. Bureau of Workers' Compensation (BWC)

Do you have any open Workers' Compensation claims?.....  Yes  No

If yes, please provide BWC claim number: \_\_\_\_\_

SERS will notify your health plan of any open Workers' Compensation claims.

**Please Complete Section C, D, E, F, and G.**

### 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 the Part B reimbursement from SERS.

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 \_\_\_\_\_

**D. SUPPLEMENTAL COVERAGE**

**1. Dental Plan**

You may enroll in a dental plan. Monthly premiums will be deducted from your pension payments. If you do not enroll now, you can enroll during the next open enrollment period.

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

Spouse's name \_\_\_\_\_

Child(ren)'s name(s) \_\_\_\_\_

**2. Vision Plan**

You may enroll in the vision plan. Monthly premiums will be deducted from your pension payments. If you do not enroll now, you can enroll during the next open enrollment period.

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

Spouse's name \_\_\_\_\_

Child(ren)'s name(s) \_\_\_\_\_

**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	<input type="checkbox"/> Self <input type="checkbox"/> Spouse	<input type="checkbox"/> Self <input type="checkbox"/> Spouse
State Teachers Retirement System of Ohio	<input type="checkbox"/> Self <input type="checkbox"/> Spouse	<input type="checkbox"/> Self <input type="checkbox"/> Spouse
Ohio Highway Patrol Retirement System	<input type="checkbox"/> Self <input type="checkbox"/> Spouse	<input type="checkbox"/> Self <input type="checkbox"/> Spouse
Ohio Police & Fire Pension Fund	<input type="checkbox"/> Self <input type="checkbox"/> Spouse	<input type="checkbox"/> Self <input type="checkbox"/> Spouse

**F. ELIGIBILITY WITH LAST EMPLOYER**

Are you **eligible** for health coverage through your last school employer?.....  Yes  No

If enrolled, when will your coverage end? Date: \_\_\_\_\_

If no, were you **eligible** for your school employers' health coverage three of the last five years?.....  Yes  No

**G. REEMPLOYMENT**

Your eligibility for SERS health care coverage may be affected if you or your spouse goes 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 A and B, or Medicare Part B only.

Do you plan to go back to work after you retire?.....  Yes  No

If yes, when? Date: \_\_\_\_\_



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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.