



Teachers' Retirement System of Alabama

Retirement Application Packet

Part I

This packet includes the following documents:

- Form 10 - Application for Retirement
- PEEHIP Insurance Authorization Form
- Direct Deposit Authorization Form

The Application for Retirement must be received at least 30 days and not more than 90 days prior to the effective date of retirement. The effective date of retirement must be the first day of a month.



P. O. Box 302150
Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
www.rsa-al.gov

Checklist for TRS Retirement Application

Congratulations! You are about to begin what we hope will be a long and happy retirement. This retirement packet, Part I, contains the information and forms you need to initiate the retirement process. Once we receive your completed Part I forms, you will be sent Part II: Retirement Benefit Option Selection and Tax Forms Packet. The retirement process is not complete until you have returned the Benefit Option Selection Form.

To Apply for Your TRS Retirement Benefit:

- Complete the Form 10 - Application for Retirement and detach it.
- Have your employer certify the Employer Certification portion of the Form 10.
- If you are applying for disability retirement, a Report of Disability Packet must be completed by you and your doctor and received by the TRS along with your Form 10 at least 30 days and not more than 90 days prior to the effective date of retirement.
- Complete the PEEHIP Insurance Authorization Form, which can be found on the back of the Application for Retirement.
- Complete the front page of the Direct Deposit Authorization form, then take or mail the form to your financial institution. This form will authorize the Teachers' Retirement System to remit and credit your benefit directly to your bank account and eliminate the possibility of your check being lost or stolen.
- Send the Form 10 - Application for Retirement, the PEEHIP Insurance Authorization form, and any other completed forms to: TRS, P. O. Box 302150, Montgomery, AL 36130-2150. **Your Application for Retirement must be received by the TRS at least 30 days and not more than 90 days prior to the effective date of retirement.** The effective date of retirement must be the first day of a month.
- Once we receive your Application for Retirement (Part I), you will be sent Part II: Retirement Benefit Option Selection and Tax Forms Packet. This packet will contain a retirement allowance report. All TRS retiring members automatically receive the Maximum Benefit unless a Benefit Option is chosen. Your Benefit Option Selection form must be received by the TRS prior to the effective date of retirement. Otherwise, by law you will automatically receive the Maximum Benefit which is irrevocable.**
- Make sure that the TRS has your current home address. If your home address should change, notify the TRS in writing. Important information regarding your retirement will be mailed from time-to-time directly to your home address.

Should you desire to cancel your Application for Retirement, written notice must be given to the TRS prior to your effective date of retirement. Failure to give timely notice will result in an irrevocable application.

Your retirement account will be audited both at the time of retirement and after all contributions have been remitted. Discrepancies between the contributions certified on your Application for Retirement and the contributions remitted to the TRS may affect your retirement benefits and/or your eligibility for retirement.

For further information about the retirement process, please read your TRS Member Handbook. We also encourage you to check out our website at www.rsa-al.gov. If you have questions, feel free to contact one of our retirement counselors.

As always, we will do our best to help you and all other TRS retirees enjoy their retirement years.

Application for Retirement

Teachers' Retirement System of Alabama

P.O. Box 302150
Montgomery, AL 36130-2150
334-517-7000 or 877-517-0020
www.rsa-al.gov

Member Information

Name _____ Soc. Sec. No. _____

Home Address _____ Date of Birth _____
Street or P. O. Box

City State Zip Home Phone ()

Employer _____ Work Phone ()

Type of Retirement (Check One): Service Disability (Report of Disability form must also be submitted.)

Date of Retirement (This date is always the first of a month.) _____ 1, 20____
Month Year

Name of bank/financial institution to which retirement benefit is to be deposited _____
(The properly completed Direct Deposit Authorization form must be submitted to the TRS to authorize remittance to the bank/financial institution.)

Beneficiary Designation

I am designating the following beneficiary to receive any benefit due at my death _____

Relationship to me _____ Date of Birth _____

Social Security Number _____

In the event the designated beneficiary listed above is different from that listed on my active account, I desire the change to be effective **(Check One)**:

Upon the duly executed completion of this application filed through the TRS with the Board of Control.

On the date my retirement benefit becomes due and payable.

Member Authorization

Signature of Applicant _____ Date _____

STATE OF _____, COUNTY OF _____

On this _____ day of _____, 20____, personally appeared before me, the above named individual and made oath that the statements made are true.

Notary _____

My Commission Expires: _____

Employer Certification

Date on which service of applicant will terminate _____

Closing date of last payroll of applicant _____

Job classification _____

Contract salary for full year _____

Total contributions (to be) deducted for the current scholastic year _____

Total contributions (to be) deducted after the current scholastic year _____

Days worked/days contracted for the current contract period _____

Total accrued and unused sick leave days at date of retirement for which **no lump sum payment will be made** _____

Signature of Authorized Official: _____ Work Phone: () _____

Employing Institution: _____ Date: _____

Please certify deductions for last 7 months for which contributions will be submitted.	
Jul _____	Jan _____
Aug _____	Feb _____
Sep _____	Mar _____
Oct _____	Apr _____
Nov _____	May _____
Dec _____	Jun _____

Please complete the information on the reverse side of this form.

Insurance Authorization Form

Public Education Employees' Health Insurance Plan (PEEHIP)

Part I: Members Currently Enrolled in PEEHIP Hospital/Medical

Members currently enrolled in PEEHIP Hospital/Medical coverage check the box which applies:

- I wish to continue my PEEHIP Hospital/Medical coverage.*
- I do not wish to continue my PEEHIP Hospital/Medical coverage.

Requested Date of Cancellation: Date of Retirement End of Earned Allocations

I agree to have premiums deducted from my retirement check for any months that are due but were not deducted.

Signature of Retiree _____ Date _____

Part II: Street Address Information

The Center for Medicare and Medicaid Services (CMS) requires PEEHIP to maintain physical street addresses for all Medicare eligible members and dependents. If you have a P.O. Box number as your mailing address on page 1 of Form 10, please provide us with your street address below. **Receipt of this information is critical to ensure there are no delays in processing your medical or prescription drug claims.** Your street address will not be used as a permanent mailing address, but will only be maintained in our system for informational purposes to cooperate with CMS regulations. This update will not change the address used to mail or deposit your retirement check.

Current Street Address _____

Part III: Employer Certification (to be completed by payroll/insurance official)

The final payroll deduction of \$ _____, will be deducted for _____ Month coverage.

This employee is a _____ month employee.
9, 10, 11, 12

Signature of Authorized Official _____ Date _____

Part IV: Members Enrolled in Optional Coverage Only (Dental, Vision, Indemnity, Cancer)

Persons who are not insured on a PEEHIP Hospital Medical plan and are only enrolled in the Optional coverages (Dental, Cancer, Indemnity, and Vision) can continue all four coverages or drop **two** Optionals at date of retirement. The retired state allocation will pay the premium for **two** of the Optionals without a payroll deduction for those retired members enrolled in only the Optional coverages. If you are not currently enrolled in Optional coverage, you can only enroll during Open Enrollment.*

If you are only enrolled in the Optional coverages and wish to drop down to two plans, please indicate which two plans you wish to **keep** on your date of retirement. To keep all four Optionals, mark "all." You cannot drop only one and keep three except during Open Enrollment.

- Cancer Indemnity Dental Vision All

I agree to have premiums deducted from my retirement check for any months that are due but were not deducted.

Signature of Retiree _____ Date _____

Part V: Non-Participating System

Persons whose public education employer does not participate in PEEHIP Hospital/Medical will be provided with information and an enrollment form about PEEHIP. If you wish to enroll in PEEHIP Hospital/Medical, complete an enrollment form and submit it with the payment for the first month's premium no later than your effective date of retirement. You cannot enroll in PEEHIP Dental or other Optional coverage at your retirement, but you can during Open Enrollment.

I agree to have premiums deducted from my retirement check for any months that are due but were not deducted.

Signature of Retiree _____ Date _____

Part VI: Vested Members Not Currently Enrolled

If you are **not** currently employed in public education in Alabama, you are eligible to enroll in the Hospital/Medical insurance through PEEHIP on your date of retirement. Please indicate your intentions below and an enrollment form will be provided to be completed and returned no later than your date of retirement with the payment for the first month's premium.

- I wish to enroll in the PEEHIP Hospital/Medical coverage effective the date of my retirement.
- I do not wish to enroll in the PEEHIP Hospital/Medical coverage.

* For members enrolled in both the PEEHIP Hospital/Medical coverage and one or more Optional coverages: A member cannot drop Optional coverages (Dental, Vision, Indemnity, Cancer) until Open Enrollment. Hospital/Medical coverage will be dropped the first day of the month following receipt of notification. Optional coverages can only be added during Open Enrollment.



RSA Direct Deposit Authorization

Retirement Systems of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Your SSN

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Check One: Retiree Beneficiary of Deceased Retiree/Member

Your Information

No initials please

Name _____
First Middle/Maiden Last

Address _____
Street or P.O. Box City State ZIP Code

Daytime Telephone (_____) _____ Email Address _____

Date of Birth _____

Indicate the system(s) from which you would like your benefit(s) direct deposited.

- Employees' Retirement System
- Teachers' Retirement System
- PEIRAF
- Judicial Retirement Fund
- RSA-1 (Annual or Monthly Distribution Only)

Account Holder Certification

I agree to notify the Retirement Systems of Alabama (RSA) immediately of the death of the recipient of the retirement benefits being deposited to this joint financial institution account, and to return all payments to the RSA that are deposited to this account after said death. The RSA will determine and pay any survivor benefits. The RSA is authorized to make necessary debit entries to this joint account for any credits that were made in error.

Joint Financial Institution Account Holder(s) Name(s)

Joint Financial Institution Account Holder(s) Signature(s)

Date _____

Signature Certification

Each benefit payment is to be credited to my account at the financial institution specified on the reverse side of this form and such payment will be in full payment, satisfaction, and discharge of the amount then falling due and payable to me on account of such payments.

If my death occurs prior to the due date of any payment made by the RSA in compliance with this request or if adjustments are required for any credit entries to my account, I authorize the RSA to make the necessary debit entries to my account. I hereby reserve the right to revoke or cancel this request, such revocation or cancellation to take effect within 30 days of receipt of written notice by the RSA.

I authorize my payment to be sent to the financial institution named on the reverse side of this form to be deposited to the designated account.

Sign Here → Your Signature _____ Date _____

Note: The retiree or beneficiary of a deceased retiree must complete this page. Then take or mail both pages to your financial institution to verify your information. Your financial institution must complete the second page and agree to the Master Agreement.

RSA Direct Deposit Authorization

Name _____ SSN

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Financial Institution Information

To be completed by a representative of the financial institution

Depositor Account No _____ Bank Routing No _____
Financial Institution Name _____ Type of Account Checking Savings
Mailing Address _____
Street or P.O. Box City State ZIP Code
Name(s) of Person(s) on this Account _____

Financial Institution Certification

MASTER AGREEMENT

In accordance with the provisions of Section 3.6.4 of the 2012 National Automated Clearing House Association (NACHA) Operating Rules and Guidelines, both the Retirement Systems of Alabama (RSA), as the Originator, and the above named Financial Institution consider the following to be the Master Agreement, as defined by the NACHA Operating Rules and Guidelines, and agree that it is to be applicable to all payments sent by the RSA to the Financial Institution for the benefit of all benefit recipients having accounts with the Financial Institution.

In consideration of the RSA making benefit payments in accordance with this Direct Deposit Authorization without requiring proof that the retiree/beneficiary identified on this form is alive on the date on which such benefits are paid and are credited to his or her account, the Financial Institution agrees to repay and refund to the RSA, on demand, the full amount of any payments made to and received by the Financial Institution after the date of death of the benefit recipient, regardless of whether the account listed on this Direct Deposit Authorization contains sufficient funds for the refund. The Financial Institution further agrees to accept the certification of the RSA as to the date of death of such payee as sufficient evidence in accordance with Section 2.10 of the 2012 NACHA Operating Rules and Guidelines.

I, the undersigned, confirm that the identity of the above named retiree/beneficiary, account number, and type are true and accurate. As the representative of the above named Financial Institution, I certify that the Financial Institution agrees to receive and deposit the identified payments in accordance with the Master Agreement and pursuant to Section 3.6.4 of the 2012 NACHA Operating Rules and Guidelines, and that the Master Agreement is applicable to all payments sent by the RSA to the Financial Institution for the benefit of the retiree/beneficiary.

Representative Name _____

Sign Here →
Financial Institution

Representative Signature _____ **Date** _____
Telephone _____

Please return completed form to:

The Retirement Systems of Alabama
P.O. Box 302150
Montgomery, AL 36130-2150
Fax: 334.517.7001

Note: Properly completed Direct Deposit Authorization forms received by the RSA before the 15th of each month will be effective for the current month..