ERS OF ALABAMA

Service Retirement Application Packet

State Employees - Part I

Congratulations!

You are about to begin what we hope will be a long and happy retirement.

PART I of your retirement process contains the information and forms you need to initiate the retirement process. Once we receive your completed Part I forms, the ERS will send the Retirement Application Packet Part II. **The retirement process is not complete until you have returned the RSA Retirement Benefit Option Selection form in Part II.**

START TODAY

This document includes the following forms:

- **ERS Application for Service Retirement**
- **ERS/JRF Insurance Authorization**
- **RSA Direct Deposit Authorization**

IMPORTANT INFORMATION

- The ERS Service Retirement Application Packet Part I 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.
- It is the responsibility of the member to ensure all forms are mailed to the RSA.

CONTACT US

Please contact Member Services at 877.517.0020 if you have any questions.

Make sure that the ERS has your current home mailing address. You can change your mailing address online at https://mso.rsa-al.gov or by completing the Address Change Notification form. Important information regarding your retirement will be mailed from time to time to your home mailing address.

FORM INSTRUCTIONS

1. Complete the first 4 sections of the **ERS Application for Service Retirement**. Have your employer complete the Employer Certification section.
2. Complete the **ERS/JRF Insurance Authorization** form. **Please do not forget to sign the bottom of this form.**
3. Complete the first page of the **RSA Direct Deposit Authorization** form. Send this form to your financial institution to complete the second page. This form will authorize the ERS to remit and credit your benefit directly to your bank account and eliminate the possibility of your check being lost or stolen.
4. Send the **ERS Application for Service Retirement**, **ERS/JRF Insurance Authorization**, and any other completed forms to:

   ERS
   P.O. Box 302150
   Montgomery, AL 36130-2150

The **ERS Service Retirement Application Packet Part I** must be received by the ERS 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 the month.

FREQUENTLY ASKED QUESTIONS

Q. How do I designate multiple beneficiaries?

Leave the Beneficiary Designation section on the ERS Application for Service Retirement form blank and submit the Multiple Beneficiaries Attachment form. The Multiple Beneficiaries Attachment form is only for members who select the Maximum Benefit or Option 1 on the RSA Retirement Benefit Option Selection form in Part II. You may download the form from the RSA website, www.rsa-al.gov, or request it from Member Services.

Q. How do I apply for disability retirement?

If you are applying for disability retirement, please do not complete this ERS Service Retirement Application Packet Part I. For disability retirement, please complete the ERS Disability Retirement Application Packet Part I. You and your physician must also complete the Report of Disability Packet. You may download the packet from the RSA website, www.rsa-al.gov, or request it from Member Services.

Q. What happens after I turn in my retirement application?

Once we receive your ERS Service Retirement Application Packet Part I, you will be sent the Retirement Application Packet Part II. This packet will contain your retirement allowance report. Your RSA Retirement Benefit Option Selection form must be received by the ERS prior to the effective date of your retirement. Otherwise, by law you will automatically receive the Maximum Benefit, which is irrevocable.

Q. How do I cancel my retirement application?

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

Q. What is PLOP?

The Partial Lump Sum Option Plan (PLOP) allows you to receive a lump-sum amount at the time of retirement in addition to your monthly retirement benefits. Election to receive a PLOP distribution will reduce your lifetime monthly benefit. The amount of this reduction is dependent on the PLOP distribution amount.

Q. Could my retirement benefits change?

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 ERS Application for Service Retirement and the contributions remitted to the ERS may affect your retirement benefits and/or your eligibility for retirement.

Q. What if I have more questions about my retirement?

For further information about the retirement process, please read your ERS Member Handbook. We also encourage you to visit 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 ERS retirees enjoy their retirement years.

Questions?

- » Visit RSA's website at www.rsa-al.gov
- » Email ERS through the RSA website; click on the "Contact" link at the top of the page
- » Call ERS at 877.517.0020
- » Attend an ERS Retirement Preparation Seminar

ERS OF ALABAMA

ERS Application for Service Retirement

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

Your SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

Your Information

Name _____
First Middle/Maiden Last

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

Telephone Number _____ Email Address _____

Date of Birth _____

Retirement Information

A completed DIRECT DEPOSIT AUTHORIZATION must be submitted to the ERS to authorize remittance to the bank/ financial institution.

Employer _____

Check One: ☐ Service Retirement
☐ Service Retirement with an interest in PLOP *(Partial Lump Sum Option Plan information will be provided to you.)*
Amount of PLOP requested $ _____ *(Amount must be in $1,000 increments.)*

Date of Retirement _____ *(This date is always the first of a month.)*

Complete **only** if employing agency allows conversion of sick leave days to retirement credit: **(check one)**
☐ I wish to have accrued unused sick leave days converted to retirement service credit.
☐ I wish to receive a lump sum payment for my unused sick leave in lieu of retirement service credit.

Beneficiary Designation

Divorce or annulment of a marriage shall not revoke or void the designation of a spouse as beneficiary for any benefits payable by RSA.

The beneficiary to whom I should like to receive any benefit due at my death _____

Relationship to me _____ Sex ☐ Male ☐ Female

Social Security Number _____ Date of Birth _____

If the designated beneficiary listed above is different from that listed on my active account, make the change effective **(check one)**:
☐ Upon the submission of this signed and notarized application to the ERS.
☐ On the date of my retirement.

Member Authorization

Sign Here

Please have your signature acknowledged before a Notary Public.

Your Signature _____ **Date** _____

State of _____, County of _____

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

Signature of Notary Public _____ My Commission Expires _____

Employer Certification

To be completed by the employing agency

No contributions should be made on lump-sum leave pay.

Notify ERS of any changes (e.g. contributions,sick leave etc.).

Sign Here →

Last date of compensated employment _____

Date of Termination _____

Retiring Employee's Job Classification _____

Additional wages with date paid _____
(i.e. extra pay period, overtime, etc.)

Indicate/explain periods with no wages _____
(i.e. leave without pay, etc.)

Project/certify amount of wages for last 4 months for which contributions will be submitted:

Oct		Apr	
Nov		May	
Dec		Jun	
Jan		Jul	
Feb		Aug	
Mar		Sep	

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

Employer Signature _____ **Date** _____

Telephone Number _____

ERS/JRF Insurance Authorization

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

Your SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

Your Information

Name _____
First Middle/Maiden Last

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

Telephone Number _____ Email Address _____

Date of Birth _____

Health Insurance Election

If you have any questions, please contact the State Employees' Insurance Board (SEIB) at 866.836.9737.

I wish to continue my insurance under the healthcare plan I have selected below, *(provided you have at least 10 years of creditable coverage with SEIB)*. I authorize monthly premium deductions from my retirement check until otherwise notified by me, or , in case of death, my beneficiary or other proper authority.

Select **Only One**: ☐ State Employees' Health Insurance Plan (BCBS) ☐ BCBS Supplemental ☐ Southland Optional Plan

I wish to **discontinue** my ☐ health coverage ☐ dental coverage

I wish to **discontinue** my dependent health insurance coverage for the individuals listed below:

First Name	Middle Name	Last Name	DOB	Sex	Relationship to Me

Credit Union Deductions

I authorize the Employees' Retirement System or Judicial Retirement Fund to deduct $ _____ from my monthly benefit payment and transmit the amount deducted to the following credit union.

☐ Alabama State Employees' Credit Union ☐ Alabama One Credit Union ☐ Guardian Credit Union

Miscellaneous Insurance Deductions

*Only available to **active** members who are applying for retirement*

Company Name	Policy Number	Monthly Premium

Sign Here → *Member*

Your Signature _____ **Date** _____

THIS BOX IS FOR ERS/JRF USE ONLY

Years of Service _____ Months of Service _____ Effective Date of Retirement _____

Type of Retirement ❑ Service ❑ Disability DROP Participant ❑ Yes ❑ No DROP Ended Date _____

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 ___ ___ ___ ___ ___ ___ ___ ___ ___

Direct Deposit from which System(s): ☐ TRS ☐ ERS ☐ JRF ☐ PEIRAF ☐ RSA-1 *(Annual or Monthly Distribution Only)*

Your Information

No initials please

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

Name _____
First Middle/Maiden Last

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

Telephone Number _____ Email Address _____

Date of Birth _____

Check One: ☐ Retiree ☐ Beneficiary of Deceased Retiree or Member

If you are a beneficiary, please provide the following for the deceased retiree or member.

Name _____ SSN _____

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 or member 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

This page to be completed by a representative of the financial institution.

Name _____ **SSN** ___ ___ ___ ___ ___ ___ ___ ___ ___

Financial Institution Information

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 Number _____

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 13th of each month will be effective for the current month.