TRS OF ALABAMA

Service Retirement Application Packet

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 TRS 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:

- **TRS APPLICATION FOR SERVICE RETIREMENT**
- **PEEHIP INSURANCE AUTHORIZATION**
- **RSA DIRECT DEPOSIT AUTHORIZATION**

IMPORTANT INFORMATION

- The TRS APPLICATION FOR SERVICE 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.
- It is the responsibility of the member to ensure all forms are mailed to the TRS.

CHANGE OF ADDRESS

Having your current mailing address on file with the TRS is very important.

- Please ensure your employer also has your current mailing address.
- Active members must change their address with their employer.
- After retirement, you may change your address online at https://mso.rsa-al.gov or by completing the ADDRESS CHANGE NOTIFICATION form.
- Important information regarding your retirement will be mailed to your current mailing address.

CONTACT US

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

FORM INSTRUCTIONS

1. Complete the **TRS Application for Service Retirement** in its entirety. Incomplete forms will be returned to the member for completion.
2. Complete the **PEEHIP Insurance Authorization** form. **Please do not forget to sign this form where needed.**
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 TRS 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 **TRS Application for Service Retirement**, **PEEHIP Insurance Authorization**, and any other completed forms to:

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

Your **TRS Application for Service 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 the month.

FREQUENTLY ASKED QUESTIONS

Q. How do I designate multiple beneficiaries?

Leave the Beneficiary Designation section on the TRS 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 form. For disability retirement, you must complete the TRS Disability Retirement Application Packet Part I and you and your physician must complete the Report of Disability Packet. You may download the forms from the RSA website, www.rsa-al.gov, or request them from Member Services.

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

Once we receive your TRS Service Retirement Application Packet Part I, we will contact your employer for your final salary and sick leave information. Your benefits will then be calculated and the Retirement Application Packet Part II, which contains your retirement allowance report, will be mailed to you. Your RSA Retirement Benefit Option Selection form must be received by the TRS 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 TRS Application for Service 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.

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 by your employer and the contributions remitted to the TRS 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 TRS 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 TRS retirees enjoy their retirement years.

- Questions?
  - » Email TRS through the RSA website; click on the "Contact" link at the top of the page
  - » Call TRS at 877.517.0020
  - » Attend a TRS Retirement Preparation Seminar

TRS OF ALABAMA

TRS Application for Service Retirement

Teachers' 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

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

Telephone Number _____ Email Address _____

Date of Birth _____ PID (optional) _____

Retirement Information

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.)*

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.

If you are naming multiple beneficiaries, please use the MULTIPLE BENEFICIARIES ATTACHMENT form located on our website.

The DESIGNATION OF BENEFICIARY PRIOR TO RETIREMENT form **will not** be accepted for retirement purposes.

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

Name _____
First **Middle/Maiden** **Last**

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 TRS.

❑ On the date of my retirement.

Signature Certification

Sign Here → *Member*

Please have your signature acknowledged before a Notary Public.

Your Signature _____ **Date** _____

State of _____ , County of _____

I, _____ , a Notary Public, hereby certify that the above named individual whose name is signed to the foregoing document, personally appeared before me and acknowledged under oath that the statements made are true. Given under my hand this _____ day of _____ , 20 _____.

Seal

Signature of Notary Public _____

My Commission Expires _____

TRS OF ALABAMA

TRS Application for Service Retirement
PEEHIP Insurance Authorization

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

Your SSN ___ ___ ___ ___ ___ ___ ___ ___ ___ **PID** _____

Name _____

Hospital Medical Information

Members currently enrolled in PEEHIP Hospital Medical coverage, check the box which applies:
I wish to ❑ continue or ❑ cancel my PEEHIP Hospital Medical coverage.
Requested Date of Cancellation ❑ Date of Retirement ❑ End of Extra Coverage Months
I agree to have premiums deducted from my retirement check for any months that are due but were not deducted.

Sign Here → **Your Signature** _____ **Date** _____
Member

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 the TRS Application for Service Retirement form, 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 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 _____

Optional Coverage Plans

Complete if enrolled in Dental, Vision, Indemnity, and/or Cancer coverages **only**.

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

If you are only enrolled in the Optional Coverage Plans 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.

❑ Dental ❑ Vision ❑ Indemnity ❑ Cancer ❑ All

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

Sign Here → **Your Signature** _____ **Date** _____
Member

Non-Participating Universities and Vested Members Not Currently Enrolled

Members from non-PEEHIP-participating universities and vested members applying for retirement:
You are eligible to enroll in hospital medical insurance through PEEHIP at the time of your retirement.

PEEHIP will send you an information packet about PEEHIP and an enrollment form after the RSA receives your TRS Application for Service Retirement or your TRS Application for Disability Retirement.

Please note that you cannot enroll in PEEHIP Optional Coverage plans (dental, vision, indemnity, cancer) at the time of your retirement, and you cannot enroll dependents who are not currently covered under PEEHIP (with the exception of active university employees, who may keep their covered dependents enrolled). Optional and dependent enrollments must be completed during annual 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 ___ ___ ___ ___ ___ ___ ___ ___ ___

Direct Deposit from System(s): ❑ TRS ❑ ERS ❑ JRF ❑ MRS ❑ SNU ❑ 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

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

Telephone Number _____ Email Address _____

Date of Birth _____ PID (optional) _____

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** _____

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 National Automated Clearing House Association Operating Rules and Guidelines, as amended (the "NACHA Rules"), 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 Rules, and agree that it is to be applicable to all payments subject to Section 3.6 of the NACHA Rules, including but not limited to all payments sent by the RSA to the Financial Institution for the benefit of all benefit recipients having accounts with the Financial Institution, notwithstanding any other provision of the NACHA Rules.

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 2.11 and any other provision(s) of the NACHA Rules that may be applicable.

I, the undersigned, confirm that the identity of the above-named retiree/beneficiary, account number, and type are true and accurate.

As an authorized signatory and 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 NACHA Rules, 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.

By affixing my signature below, I represent and warrant that I have full authority to execute this Master Agreement on behalf of the above-named Financial Institution.

Representative Name _____

Sign Here ➔ **Representative Signature** _____ **Date** _____

Financial Institution

Telephone Number _____

Please return completed form to:

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

Properly completed Direct Deposit Authorization forms received by the RSA before the 13th of each month will be effective for the current month.