



# Disability Retirement Forms

# Application for Disability Retirement



Teachers Retirement System of Georgia

If you are mentally or physically disabled (not able to satisfactorily perform your current work duties due to health reasons), and you have at least 10 years of creditable service, you are eligible to apply for disability retirement with the Teachers Retirement System of Georgia (TRS).

## ▼ To Be Completed by Member -- please print clearly

### Your Information

Please print or type all personal information. Incomplete information will delay the processing of your retirement benefit.

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Social Security Number

Title (Mr, Ms etc.)      Last Name      First Name      Middle Initial

(      )      Date of Birth (mm/dd/yy)      Sex (M or F)

Phone Number (daytime)

Street Address (home address)

City      State      Zip Code

### Your Date of Retirement

Please indicate the date you would like your retirement to be effective.

I hereby apply for disability retirement effective on the first day of \_\_\_\_\_, 20 \_\_\_\_\_, and elect to have my monthly retirement allowance payable as indicated under "Your Retirement Plan."

**Note:** To be eligible for retirement for the date listed above, you may not work at any time during that month. Working one day during the month you plan to retire will postpone your retirement until the following month.

### Your Retirement Plan

Before you select ONE PLAN, please reference the TRS Member's Guide available at [www.trsga.com](http://www.trsga.com) under the Publications section or at the TRS office.

If you are interested in the amount of benefits you are eligible for under the various plans of retirement, please contact TRS for an estimate.

It is very important that you understand the retirement plan you are selecting, because once your first payment is deposited, you cannot change your plan of retirement except under very limited conditions.

PLANS for monthly benefit to member and a refund only to beneficiaries (no monthly benefit to beneficiary(ies)):

- Plan A
- Plan B Option 1

PLANS for monthly benefit to member and monthly benefit only to beneficiaries. (You may have multiple beneficiaries, but no adjustment is made to the benefit if any or all beneficiaries predecease you.)

- Plan B Option 2
- Plan B Option 3
- Plan B Option 4

In accordance with my selection of Option 4, I designate a dollar amount of \$ \_\_\_\_\_ OR percentage of \_\_\_\_\_% to be paid to the beneficiary(ies) listed in the Selection of Beneficiary sections. (Select either a dollar amount or percentage, not both.)

PLANS for monthly benefit to member and monthly benefit only to a single beneficiary. (You may have only one beneficiary and the benefit is adjusted if the beneficiary predeceases you.)

- Plan B Option 2 - Pop Up
- Plan B Option 3 - Pop Up



D I S A B I L I T Y

# Application for Disability Retirement cont.

## Selection of Primary Beneficiary

If you have more than one primary beneficiary, please complete the Designation of Multiple Beneficiaries (MB-1) form.

Beneficiary(ies) designations made on this form supercede any other beneficiary(ies) designations on file with TRS.

In accordance with the retirement plan selected, I hereby designate my *primary* beneficiary (*please check only one*):

below OR  on the attached Designation of Multiple Beneficiaries form (MB-1)

\_\_\_\_\_  
Name of Beneficiary Relationship Sex (M or F)

\_\_\_\_\_  
Social Security Number Date of Birth (mm/dd/yy)

\_\_\_\_\_  
Street Address (home address)

\_\_\_\_\_  
City State Zip Code

## Selection of Secondary Beneficiary

**A secondary beneficiary is eligible to receive a refund of remaining contributions and interest, but not a monthly benefit, upon the death of the member and primary beneficiary(ies).**

If you have more than one secondary beneficiary, you will need to complete the Designation of Multiple Beneficiaries (MB-1) form.

In accordance with the retirement plan selected, I hereby designate my *secondary* beneficiary (*please check only one*):

below OR  on the attached Designation of Multiple Beneficiaries form (MB-1)

\_\_\_\_\_  
Name of Beneficiary Relationship Sex (M or F)

\_\_\_\_\_  
Social Security Number Date of Birth (mm/dd/yy)

\_\_\_\_\_  
Street Address (home address)

\_\_\_\_\_  
City State Zip Code

## Emergency Contact Information

In an effort to protect the distribution of your retirement benefit, TRS requests that you provide an emergency contact person (someone other than your beneficiary(ies) whom you trust to handle your affairs) should all persons on file be unavailable.

\_\_\_\_\_  
Name of Emergency Contact Relationship Sex (M or F)

\_\_\_\_\_  
Social Security Number Date of Birth (mm/dd/yy)

\_\_\_\_\_  
Street Address (home address)

\_\_\_\_\_  
City State Zip Code

## Important Information

- ◆ Applications for disability retirement cannot be accepted in the TRS office more than 90 days prior to the effective date of retirement.
- ◆ Your employer(s) must complete a Retirement Certification Report for you and submit it to TRS. Your retirement application is not considered complete until these forms arrive in the TRS office.
- ◆ Upon receipt of your application for disability retirement and all of your medical information, we will provide you written notification of the status of our progress in processing your application.
- ◆ The more medical data you provide, the more information the TRS Medical Board will have on which to base their decision. If there is insufficient information about the disabling impairment(s), we will arrange for a special examination or test with an appropriate treatment source to gather the necessary information. Any such examination will be at the expense of TRS and every effort will be made to schedule this appointment with a provider as close as possible to your area of residence.

# Application for Disability Retirement cont.

## Payment Method

With the exception of your first monthly check, which will be mailed to your home address, your subsequent monthly checks will be electronically sent to your financial institution. *Please check only one option.*

Your monthly benefit checks are automatically deposited into your banking account via Electronic Funds Transfer (EFT).

- I wish to deposit my benefit checks into my **CHECKING** account. **My VOIDED CHECK is attached below.**
- I wish to deposit my benefit checks into my **SAVINGS** account. **My VOIDED DEPOSIT SLIP is attached below.**

*(Please use transparent tape across top edge of check or deposit ticket. Do not staple or glue.)*

### To have funds deposited to you:

**CHECKING ACCOUNT:** Please tape a VOIDED CHECK inside this box.

**SAVINGS ACCOUNT:** Please tape a VOIDED savings account DEPOSIT SLIP inside this box.

I authorize the Teachers Retirement System of Georgia (TRS) to deposit my net monthly retirement benefit to my account at the financial institution specified. If necessary, I also authorize and request that this financial institution accept any adjusting entries initiated by TRS.

Your net retirement benefit will be deposited into your account *on the first business day of each month*. A change in your account number will require your benefit to be mailed to your home address until the first business day of the month following the issuance of another prenote to your financial institution.

On the first business day of the month when your EFT services are scheduled to start, you should verify that your financial institution received your deposit. If your deposit has not been made by the second business day of the month, call TRS immediately. Please notify TRS immediately if your financial institution changes your account number and/or routing number.

You will receive notice from TRS only when there is a change in your monthly net benefit. Should any change occur, TRS will send you a notice of the change(s) and the new amount deposited to your account.

**Required Disability Forms:** In addition to this form, I understand that the following forms must be completed and submitted before my application can be considered: *Member's List of Disability Information that you must complete; Physician's Report that your physician(s) must complete; Psychiatrist's, Psychologist's, Counselor's Report that your treatment provider must complete (if applicable); and Hospital/Clinic Report that must be completed by the hospital/clinic from which you received treatment.*

**Payment Method:** With the exception of my first monthly check, which will be mailed to my home address, I understand that my subsequent monthly benefit checks will be electronically sent to my financial institution.

**Required Identification Documents:** In accordance with the requirements for retirement application, I have attached photocopies of personal identification containing the date of birth for myself and my beneficiary(ies). Acceptable forms of ID are listed on the TRS website. My application will not be processed without this identification.

**Service Credit for Retirement:** I understand that it is my responsibility to purchase all available service credit PRIOR to the effective date of my retirement. It is my responsibility to contact TRS to purchase this service credit. Should I not purchase such service prior to the effective date of my retirement, I understand that I MAY NOT purchase additional service after my retirement date is effective (no exceptions allowed).

**Changing Retirement Plans:** Once my monthly benefit payment has been mailed, I cannot change my plan of retirement except under the limited conditions specifically stated in Georgia law.

*continued on the next page*

# Application for Disability Retirement cont.

**Changing Beneficiaries:** I understand that if I have selected Plan A or Plan B - Option 1, I may change my designation of beneficiary(ies) at any time prior to my death. If I have selected Plan B - Option 2 or 2 Pop Up, Option 3 or 3 Pop Up, or Option 4, I cannot change my beneficiary(ies) except under the limited conditions specifically stated in Georgia law.

**Active Membership:** I understand that should my death occur within 30 days of my effective retirement date, I will be considered an active member at the time of my death in accordance with Georgia law. My account will be settled as a death in service in accordance with the active member beneficiary designation(s) I have selected on this retirement application.

**Re-activating Membership:** I understand that should I return to work in a position covered by TRS, I must notify TRS immediately.

**Taxes:** As required by federal regulations, TRS will withhold federal taxes, based on married and 3 allowances, from the taxable portion of your monthly benefits unless you complete and submit to TRS a federal form W-4P where you may indicate not to have withholding apply or to have withholding apply at a different rate. Georgia law also considers your benefits taxable but does not require withholding. I understand that I may elect to have Georgia taxes withheld by completing Georgia tax form G-4 and submitting it to TRS. Failure to withhold may result in tax penalties.

## Your Signature

Please sign and date verifying the information provided on all four pages of this application is accurate.

By signing below,

I verify that the information provided on all four pages of this Application for Disability Retirement is accurate;

I authorize the Teachers Retirement System of Georgia (TRS) to deposit my net monthly retirement benefit to my account at the financial institution below. If necessary I also authorize and request that this financial institution accept any adjusting entries initiated by TRS;

I acknowledge that I have read and understand the plans of retirement and the provisions for optional allowances available to me. Once my first benefit payment has been deposited, I cannot change my plan of retirement except under the limited conditions stated in Georgia law;

I understand that the beneficiary designation(s) I have listed on this application supersede any other beneficiary designation(s) on file with TRS. Once this application is received by either TRS or my school system, my beneficiary designation(s) is considered valid; and

I understand that all required medical forms must be completed and received by TRS in order for the TRS Medical Board to consider my Application for Disability.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Physician's Report



**This form must be filled out if you are applying for Disability Retirement.**

As a member of the Teachers Retirement System of Georgia (TRS), it is your responsibility to obtain the necessary medical information from all treating sources needed to determine the status of your disability retirement request. Any charges for this information will be at your expense. In some cases, TRS may require an evaluation by an independent physician of our choice. If this is necessary, you will be notified and TRS will assume the responsibility for that cost only.

You need to send one of these reports to each physician from whom you have received treatment/diagnosis for your medical condition(s) in the last 12 months. Please attach a copy of your current job description to each report. Job descriptions are available from your personnel department.

TRS guarantees the confidentiality of the information provided on this form.

## ▼ To Be Completed by Member -- please print clearly

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Social Security Number

\_\_\_\_\_

Date of Birth

\_\_\_\_\_

Last Name

\_\_\_\_\_

First Name

\_\_\_\_\_

Middle Initial

\_\_\_\_\_

Street Address or P.O. Box

(\_\_\_\_\_) \_\_\_\_\_

Telephone Number (daytime)

City

State

Zip Code

\_\_\_\_\_

Name of Physician

(\_\_\_\_\_) \_\_\_\_\_

Physician's Phone Number

\_\_\_\_\_

Address of Physician

\_\_\_\_\_

City

\_\_\_\_\_

State

\_\_\_\_\_

Zip Code

## Authorization for Release of Medical Information

This is my written authorization to release to the Teachers Retirement System of Georgia any and all medical records and information for the purpose of processing my disability retirement application. This includes any psychiatric/psychological records.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

After completing this section, please forward this report to your physician. If you have been treated/diagnosed by more than one physician in the last 12 months, you must send a copy of this report to each one. Do not forget to attach a copy of your job description to each report

## ▼ To Be Completed by Physician -- please print clearly

Please document diseases, diagnoses and current condition(s). Please include copies of test results, notes from office visits, blood tests, and x-ray reports for the past 12 months. Be sure to include any records that prove the medical diagnosis.

This person has applied for disability retirement with the Teachers Retirement System of Georgia and you have been named as a treating physician. Your information is vital in determining disability status for the job currently held. A job description is attached for your review. TRS needs a current evaluation. Please state specifically whether or not you determine that this person is disabled for the current job held. The person has signed above authorizing the release of all medical information.

Please bill the person named above for any charges relating to this request. Thank you for your cooperation.

## Ability to Perform Job

For the currently held position, and according to the job description attached, I find that this person is:

Able to perform the job as described.

Yes

No



M E D I C A L

# Physician's Report cont.

▼ **To Be Completed by Physician** -- please print clearly

## Job Duties

Please state the job duties that the person cannot perform.

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## Disability Diagnosis

Please state the diagnosis for the cause of the disability.

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## Physical Findings & Test Results

Please state the specific physical findings and test results confirming this diagnosis.

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Please send copies of these test results. If cancer is involved, attach copies of the confirming pathology reports. If AIDS is involved, attach copies of HIV and CD4 test reports. If you do not have copies of these reports, please tell us where they can be obtained.

## Abnormalities

Please state the specific abnormalities disabling this patient.

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## Recovery

Using the attached job description, can this patient be expected to recover sufficiently to return to the described job?

Yes       No      If yes, please state an approximate time.

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## Treatment

Please state the treatment you have recommended.

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Has the patient followed through with the recommended treatment?

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State dates and results of treatment.

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## Referrals

If you have referred this patient to any specialists, please list them.

Name	Specialty	Address	Date of Referral
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_____	_____	_____	_____
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_____	_____	_____	_____
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## Other Information

Please provide any other information that you think will assist in the determination of this patient's claim for disability. If more space is needed, please explain on a separate page and attach to this report.

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## Physician's Authorization

By signing, you certify that the information provided above is accurate.

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Physician's Name Printed

Confidentiality will be maintained.

\_\_\_\_\_  
Patient's Last Name, First Name

\_\_\_\_\_  
Date

After completing this report, please forward it, along with any attachments, directly to TRS. We appreciate your assistance.

page 2 of 2

# Member's List of Disability Information



Teachers  
Retirement  
System of  
Georgia

**This form must be filled out if you are applying for Disability Retirement.**

Please provide TRS with the physicians (including specialists), psychologists, psychiatrists, hospitals and/or clinics you have seen in the last 12 months from whom you are requesting medical information relating to your disability.

Be sure to provide complete information for each provider. Please send this form with your Application for Disability Retirement form to TRS. If you need additional space, please use the back of this page.

## ▼ To Be Completed by Member -- please print clearly

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Social Security Number

Date of Birth

Last Name

First Name

Middle Initial

Street Address or P.O. Box

( )  
Telephone Number (daytime)

City

State

Zip Code

Name of Provider

( )  
Phone Number

Address (street, city, state, zip code)

Date Last Seen

Date of Next Appointment

Reason for Treatment

Name of Provider

( )  
Phone Number

Address (street, city, state, zip code)

Date Last Seen

Date of Next Appointment

Reason for Treatment

Name of Provider

( )  
Phone Number

Address (street, city, state, zip code)

Date Last Seen

Date of Next Appointment

Reason for Treatment

Name of Provider

( )  
Phone Number

Address (street, city, state, zip code)

Date Last Seen

Date of Next Appointment

Reason for Treatment

Name of Provider

( )  
Phone Number

Address (street, city, state, zip code)

Date Last Seen

Date of Next Appointment

Reason for Treatment



M E D I C A L

# Psychiatrist's, Psychologist's or Counselor's Report



**This form pertains to those members applying for Disability Retirement.** TRS guarantees the confidentiality of the information provided on this form.

As a member of the Teachers Retirement System of Georgia (TRS), it is your responsibility to obtain the necessary medical information from all treating sources needed to determine the status of your disability retirement request. Any charges for this information will be at your expense. In some cases, TRS may require an evaluation by an independent treatment provider of our choice. If this is necessary, you will be notified and TRS will assume the responsibility for that cost only.

You need to send one of these reports to EACH psychiatrist, psychologist, or counselor from whom you have received treatment/diagnosis for your medical condition(s) in the last 12 months. You must attach a copy of your current job description to each report. Job descriptions are available from your personnel department.

If this form is completed by a licensed social worker or psychologist, the medical doctor who referred you must sign it as well.

## ▼ To Be Completed by Member -- please print clearly

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Social Security Number

\_\_\_\_\_

Date of Birth

\_\_\_\_\_

Last Name

\_\_\_\_\_

First Name

\_\_\_\_\_

Middle Initial

\_\_\_\_\_

Street Address or P.O. Box

(\_\_\_\_) \_\_\_\_\_

Telephone Number (daytime)

\_\_\_\_\_

City

\_\_\_\_\_

State

\_\_\_\_\_

Zip Code

\_\_\_\_\_

Name of Treating Source

(\_\_\_\_) \_\_\_\_\_

Phone Number of Treating Source

\_\_\_\_\_

Address of Treating Source

\_\_\_\_\_

City

\_\_\_\_\_

State

\_\_\_\_\_

Zip Code

## Authorization for Release of Medical Information

This is my written authorization to release to the Teachers Retirement System of Georgia any and all medical records and information for the purpose of processing my disability retirement application. This includes any psychiatric/psychological records.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

After completing this section, please forward this report to your psychiatrist, psychologist or counselor. If you have been treated/diagnosed by more than one in the last 12 months, you must send a copy of this report to each one. Do not forget to attach a copy of your job description to each report.

## ▼ To Be Completed by Treating Source -- please print clearly

**Please complete all 4 pages of this form.**

This person has applied for disability retirement with the Teachers Retirement System of Georgia and you have been named as a treatment provider. Your information is vital in determining disability status for the job currently held. A job description is attached for your review. TRS needs a current evaluation. Please state specifically whether or not you determine that this person is disabled for the current job held. The person has signed above authorizing the release of all medical information. If a licensed social worker or psychologist is completing this form, it must also be signed by the referring medical doctor.

**Please bill the person named above for any charges relating to this request.** Thank you for your cooperation.

## Ability to Perform Job

For the currently held position, and according to the job description attached, I find that this person is:

**Able to perform the job as described.**

Yes

No



M E D I C A L

# Psychiatrist's, Psychologist's or Counselor's Report cont.

▼ **To Be Completed by Treating Source** -- please print clearly

\_\_\_\_\_  
Patient's Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Social Security Number

## Job Duties

Please state the job duties that the person cannot perform.

\_\_\_\_\_  
\_\_\_\_\_

## Present Illness

Please describe:

1. The patient's mental condition
2. Age at onset
3. Diagnosis
4. Symptoms supporting diagnosis (include any history of substance abuse or violent behavior)
5. Treatment (past, present, medication, response, compliance and side effects-include photocopies of progress notes and hospital discharge summaries if available)

1. \_\_\_\_\_  
\_\_\_\_\_  
2. \_\_\_\_\_  
\_\_\_\_\_  
3. \_\_\_\_\_  
\_\_\_\_\_  
4. \_\_\_\_\_  
\_\_\_\_\_  
5. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Past History

Please list the significant physical/mental factors in patient's background (serious historical illness or disability of patient or family members)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Daily Activities

Please include examples and information on how independently the patient acts, however long he/she is able to sustain activities, and the quality and appropriateness of the activities.

1. Describe a typical day (yard work, house work, cooking, TV, visiting, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Interests (hobbies, sports, social and church activities, etc.)

\_\_\_\_\_  
\_\_\_\_\_

3. Ability to relate to others (frequency of trips outside the home, frequency and quality of interactions with friends, family, neighbors, crowds, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Personal habits (appearance, grooming habits, personal hygiene, clothing, etc.)

\_\_\_\_\_  
\_\_\_\_\_

5. Current ability to function in a work setting (ability to concentrate, pay attention, sustain pace, understand and remember directions, and adapt to changes)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Psychiatrist's, Psychologist's or Counselor's Report cont.

▼ **To Be Completed by Treating Source** -- *please print clearly*

\_\_\_\_\_  
Patient's Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Social Security Number

## Current Mental Status

Please describe the following by using illustrative incidents when possible.

1. Behavior and interaction with therapists (appropriate, hostile, suspicious, aggressive, evasive, passive, dramatic, etc.)

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2. Psychomotor behavior (agitation, retardation, tics, tension, tremors, etc.)

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3. Speech (slow, loud, pressured, understandable, impaired in any way)

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4. Mood/Affect/Facial Expression (quantity, appropriateness, type, range of feelings expressed, lability, eye contact, etc.)

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5. Sensorium/Perceptual abnormalities (disoriented, delusional, hallucinations, etc.)

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6. Flow of thought (loose associations, coherent, rambling, perseverative, etc.)

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7. Content of thought (illogical, apprehensive, obsessive, suicidal, etc.)

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# Psychiatrist's, Psychologist's or Counselor's Report cont.

▼ **To Be Completed by Treating Source** -- *please print clearly*

\_\_\_\_\_  
Patient's Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Social Security Number

## Current Mental Status cont.

Please describe the following  
by using illustrative incidents  
when possible.

### 8. Memory (remote, recent, immediate)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 9. Attention and consciousness (impaired in any way by illness, injury, drugs, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 10. Estimated intelligence and ability to concentrate/focus

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 11. Reliability of patient's report

\_\_\_\_\_  
\_\_\_\_\_

### 12. Physical condition (include unrealistic beliefs about personal illness or complaints of chronic pain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 13. Specific symptoms (low energy level, insomnia, guilt, poor appetite and weight loss, anhedonia, autonomic hyperactivity, vigilance and scanning, phobias, intrusive and traumatic recollections, substance abuse, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Other Information

Please provide any other  
information that you think will  
assist in the determination of this  
patient's claim for disability.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Physician's Authorization

By signing, you certify that the  
information provided above is  
accurate.

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Signature of MH Professional

Confidentiality will be maintained.

\_\_\_\_\_  
Physician's Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
MH Professional's Name Printed

\_\_\_\_\_  
Date

After completing this report, please forward it, along with any attachments, directly to TRS. We appreciate your assistance.

page 4 of 4

# Hospital/Clinic Report



**This form must be filled out if you are applying for Disability Retirement.**

As a member of the Teachers Retirement System of Georgia (TRS), it is your responsibility to obtain the medical information necessary to determine the status of your disability retirement request. Any charges for this information will be at your expense. If you have any questions, please call TRS.

You need to send one of these reports to each hospital and/or clinic where you received treatment and/or diagnosis in the last 12 months.

TRS guarantees the confidentiality of the information provided on this form.

## ▼ To Be Completed by Member -- please print clearly

--	--	--	--	--	--	--	--	--	--

Social Security Number

Date of Birth

Last Name

First Name

Middle Initial

Street Address or P.O. Box

( )

Telephone Number (daytime)

City

State

Zip Code

Date(s) of Treatment or Diagnosis

Date(s) of Discharge

Name of Institution

( )

Institution Phone Number

Address of Institution

City

State

Zip Code

## Authorization for Release of Medical Information

This is my written authorization to release to the Teachers Retirement System of Georgia any and all medical records and information for the purpose of processing my disability retirement application. This includes any psychiatric/psychological records.

Signature

Date

After completing this section, please forward this report to your hospital/clinic. If you have been treated/diagnosed at more than one hospital/clinic in the last 12 months, you must send a copy of this report to each one.

## ▼ Instructions to Hospital/Clinic

1. Please send all information requested below that pertains to this patient:

- |                         |   |
|-------------------------|---|
| ✓ Patient History Notes | ✓ Pathology Reports   |
| ✓ Physical Notes        | ✓ Diagnostic Studies  |
| ✓ Operative Notes       | ✓ Discharge Summary for the Dates of Treatment the patient listed above |
| ✓ Radiology Reports     | ✓ Surgeon's Report  |
| ✓ Lab Reports           | ✓ Surgery Records   |

2. Please include any records regarding treatment or diagnosis for the past 12 months.

3. Please send the requested information directly to TRS at the address listed below. The information you provide is vital in the determination of disability status for this patient.

4. Please bill the person named above for any charges relating to this request. Confidentiality will be maintained. Thank you for your cooperation.



M E D I C A L

# Sick Leave Certification - Final



## ▼ To Be Completed by Member -- please print clearly

### Your Information

Print or type all personal information. When listing your name, please include all names under which you may have been employed.

\_\_\_\_-\_\_\_\_-\_\_\_\_ Social Security Number

\_\_\_\_ Last Name First Name Middle Initial

(\_\_\_\_) Telephone Number (home) (\_\_\_\_) Telephone Number (work)

\_\_\_\_ Street Address (home address)

\_\_\_\_ City State Zipcode

### Employment Information

Your date of retirement cannot be earlier than the 1st of the month following your last date of employment.

\_\_\_\_ Anticipated Last Date of Employment Anticipated Date of Retirement

\_\_\_\_ Current Employer Start Date/End Date Previous Employer Start Date/End Date

\_\_\_\_ Previous Employer Start Date/End Date Previous Employer Start Date/End Date

### Sick Leave Credit

#3--if you do not wish to receive credit for only a portion of your service time, list the employer's name and period of time you **do not** want to include.

- I want to pursue sick leave credit.
- I do not wish to pursue sick leave credit. I understand I cannot establish sick leave credit at a later date.
- I do not wish to submit sick leave verification for the following employer \_\_\_\_\_ for the following date(s) \_\_\_\_\_. I understand I cannot establish sick leave credit at a later date.

### Your Signature

Please sign and date verifying the information provided above is accurate.

\_\_\_\_ Signature Date

## ▼ To Be Completed by Employer -- please print clearly

### Sick Leave Status

Please verify the information on this form is the member's final sick leave status by checking this box.

### Sick Leave Verification

1. Please verify the Final Balance of Sick Leave subject to the qualifications listed on the back of this form. The number of sick days should be the balance prior to any lump sum payment at retirement. If applicable, list dates of missing records.

- Our personnel/payroll records show a final sick leave balance for this member of \_\_\_\_\_ days for the dates of \_\_\_\_\_ to \_\_\_\_\_.
- The total listed above reflects sick leave accrued at 1 1/4 days or less per month of service, OR  
 The total listed above reflects sick leave accrued at a rate higher than 1 1/4 days per month of service. Sick leave was awarded at \_\_\_\_\_ days per month of service. Please attach an explanation of accrual rate(s).
- We do not have sick leave records for the dates of \_\_\_\_\_ to \_\_\_\_\_.

### Sick Leave Lump-Sum Payments

The employee elected to receive \_\_\_\_\_ days of unused sick leave in a lump-sum payment upon termination; AND/OR the employee received \_\_\_\_\_ days of unused sick leave in a lump-sum payment as an attendance incentive or for any other program. Describe program on back of form.

### Your Signature

Please sign and date verifying the information provided above is accurate.

I certify that this information conforms to the personnel/payroll records of this system for this individual and the requirements outlined in the legislation and the TRS procedures for determining the amount of accumulated sick leave to be used for retirement purposes. I further certify that the above information is complete from all existing records for this person in this system.

\_\_\_\_ Approving Authority's Signature Title

\_\_\_\_ System Name Date



## Sick Leave Certification - Final cont.

**EMPLOYERS:** The accumulated sick leave that a TRS member may use for retirement credit may or may not be the final total showing on the employee's last pay stub or in your records. Policies such as forfeited leave, a leave bank, annual payments of leave, and other situations in your system may require you to recalculate the final balance for the determination of allowable retirement credit. The dates you list don't have to cover the entire employment time if records are not available. The following considerations should be observed when entering the Final Balance of Sick Leave on this form. **The Final Balance of Sick Leave should:**

- ♦ reflect the days earned based on the policies of your system for this individual employee.
- ♦ not exceed 1 1/4 days per month of service. If your policies call for days awarded in excess of 1 1/4 days per month of service, you may recalculate the total based on the limit of 1 1/4 days, or you may indicate your basis for accumulation on the form in the area provided.
- ♦ include all days forfeited due to your policy limitation of accrued leave.
- ♦ include all days to be paid in a lump-sum payment at retirement.
- ♦ not include the days for which the employee was paid when absent.
- ♦ reflect the reduction for any sick leave days used for personal leave.
- ♦ not include the days for which the employee was paid in a lump sum at the end of each year.
- ♦ reflect the reduction for any sick leave days donated to a sick leave bank and used from a sick leave bank which exceed the days donated. (For example, if an employee donates 2 days to a sick leave bank and uses 5 days sick leave from the bank, then the 2 days donated should be deducted from the Final Balance of Sick Leave.)
- ♦ not include days granted by special action of your governing body.
- ♦ not include days transferred from another system. However, if you do include any transferred days, you must indicate in the section below the number of transferred days included in the total and the system from which the days were transferred.

Number of sick days transferred included in total \_\_\_\_\_

System from which the sick days were transferred \_\_\_\_\_

**This form must be submitted AFTER the employee has terminated.** Since the employee could use sick leave just prior to his or her retirement date and, as a result, receive less sick leave credit, TRS will not adjust a member's benefit for sick leave credit until after the member has terminated.

You must also report ALL lump-sum payments to the member on the the front side of this form, which includes any attendance incentive pay that is paid out to the member at termination. Failure to report any lump-sum payments related to sick leave will result in reduced sick leave credit and a reduced retirement benefit to the member. If applicable, please describe the conditions of your attendance-incentive pay program or other program:

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**MEMBERS:** After you have filled out your portion of the form, you will need to make a copy of it for each employer you listed on the reverse and send the copy to them for your sick leave verification. Your sick leave credit cannot be calculated until forms from all employers are received at TRS. It is up to you to follow up with your employers to make sure they have submitted the form to TRS.

Your retirement will be processed without your sick leave credit. Your credit will be calculated after you are on retirement payroll with TRS and your monthly benefit will be adjusted retroactively to your date of retirement.

\*Under O.C.G.A Section 45-11-1, the falsification of state records by any public officer or other person is a felony subject to a fine and imprisonment.

\*\*The law requires you to keep the sick leave records for your past, present and future TRS covered employees for a period of 50 years.

\*\*\*Under O.C.G.A Section 47-3-141, any person who attempts to defraud the retirement system by means of false statements or falsified records is subject to a fine and imprisonment. Additionally, the board of trustees shall have the power to actuarially adjust any erroneous payments.

# Retirement Certification Report



## ▼ To Be Completed by Retiring Member's Employer -- please print clearly

### Member Information

If this is the first TRS-8 for the member, please mark the "estimated" box on the right. If you are submitting changes to a TRS-8 already sent to TRS, mark the "corrected" box. Also, please indicate the retiring member's data. The position and contract dates should be the ones in force for the final year of employment.

\_\_\_\_-\_\_\_\_-\_\_\_\_ Social Security Number

Estimated  Corrected

\_\_\_\_ Last Name  First Name  Middle Initial

\_\_\_\_ Title or Position

\_\_\_\_ Contract Dates

### Contract Type & Pay Method

If the member has had changes in position and/or his or her contract during the last three years (semester changes NOT included), please attach an explanation.

1. Contract Type (please check one)

9 or 10 month  Semester  11 month  12 month  Other \_\_\_\_\_

2. Payment Method (please check one)

12 Equal Monthly Payments  10 Equal Monthly Payments  9 Equal Monthly Payments  
 9 Equal Monthly Payments and 1 Month Summer pay  Biweekly  Other \_\_\_\_\_

**Note:** In the event you need to check more than one contract type or payment method, please attach an explanation of the changes during the year.

### Explanation of Salary & Contributions

This section should include, as accurately as possible, all information for the member's last year of employment including that which has already been reported, and any future salary and contributions. *Please read instructions on the back for more details.*

Month/ Year	Total Salary	Total Contributions	Contract Pay	Pro-rata Summer Pay	Summer Employment Pay	Other
07/	_____	_____	_____	_____	_____	_____
08/	_____	_____	_____	_____	_____	_____
09/	_____	_____	_____	_____	_____	_____
10/	_____	_____	_____	_____	_____	_____
11/	_____	_____	_____	_____	_____	_____
12/	_____	_____	_____	_____	_____	_____
01/	_____	_____	_____	_____	_____	_____
02/	_____	_____	_____	_____	_____	_____
03/	_____	_____	_____	_____	_____	_____
04/	_____	_____	_____	_____	_____	_____
05/	_____	_____	_____	_____	_____	_____
06/	_____	_____	_____	_____	_____	_____
07/	_____	_____	_____	_____	_____	_____
08/	_____	_____	_____	_____	_____	_____

Explanation of OTHER contributions listed above: \_\_\_\_\_

**1. Colleges and Universities:**  
please list semester dates

Fall \_\_\_\_\_  
 Winter \_\_\_\_\_  
 Spring \_\_\_\_\_  
 Maymester \_\_\_\_\_  
 Summer \_\_\_\_\_

**2. All Other School Systems:** please list regular and summer school year dates

Regular School Year \_\_\_\_\_  
 Summer School \_\_\_\_\_

**3. Termination Dates:** indicate the last date that the member will be at work, the last day of the contract and the last month of contributions you will be submitting.

Last Day at Work \_\_\_\_\_  
 Last Day in Contract \_\_\_\_\_  
 Last Month of Contributions \_\_\_\_\_

### Signature of Approving Authority

Please sign and date verifying the information provided is correct and submit form to TRS.

\_\_\_\_ Approving Authority's Signature  Date



\_\_\_\_ Employer Name

I certify the above named individual's employment is or will be severed as indicated and that no agreement exists to allow the employee to return to service, including service as or for an independent contractor. Any return to employment or rendering of any paid service, including service as or for an independent contractor, for any employer during the calendar month of the effective date of retirement shall render the severance invalid and nullify the employee application for retirement.

\_\_\_\_ Approving Authority's Signature  Date  Title page 1 of 2

# Retirement Certification Report *cont.*

## Explanation of Salary & Contributions Instructions

TOTAL SALARY should include only those salaries from which TRS contributions should be made. Salary subject to TRS contributions includes:

- ◆ regular contract salary (half-time or more employment)
- ◆ summer employment pay
- ◆ all pro-rata summer pay (including less than half-time employment)
- ◆ salary adjustments if part of the regular contract
- ◆ sick leave paid on a daily basis prior to retirement with a termination date at the conclusion of the payment of the sick leave
- ◆ **Not Included:** annual or vacation leave at the end of employment (terminal annual leave), retirement incentive payments, or lump sum payments for sick leave

If you have any questions regarding allowable salary subject to TRS contributions, please visit the TRS website or contact your assigned TRS representative in the Employer Services Division.

TOTAL CONTRIBUTIONS withheld or to be withheld should be listed in this column. If the total contributions withheld for a particular month include a composite of contributions, please list the breakdown of the contributions in the proper column. If you show contributions in the "Other" column, please explain in the place provided. If more space is needed, please attach an explanation to this form before submitting to TRS.

**TERMINATION DATES:** An eligible member's retirement cannot be effective until the first of the month following his/her last date of employment. If his/her last date of employment is April 30, do not show May 1 on this form. This will cause the effective date of the retirement to be June 1.

If the last month of contributions are after the termination date and they are not already explained in the spaces provided, please attach an explanation on a separate sheet of paper. (examples include: last pay due to system's payroll schedule, bi-weekly employee, etc.)

## Fluctuations in Salary and Contributions

If the member has had any unusual fluctuations in the salary and contributions during the last three years that you have not already explained, please attach an explanation on another sheet.

# Affidavit of Residency



▼ **To Be Completed by Member** -- please print clearly and mail notarized form to TRS.

## Your Information

Please print or type all personal information.

Social Security Number \_\_\_\_\_

Title (Mr, Ms etc.) \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_

Phone Number (daytime) \_\_\_\_\_ Date of Birth (mm/dd/yy) \_\_\_\_\_ Gender (M or F) \_\_\_\_\_

Street Address (home address) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## Acceptable Forms of ID

Please see the back of this form for a list of acceptable forms of identification.

**By executing this affidavit under oath, as an applicant for a(n) public retirement system monthly benefit payment, as referenced in O.C.G.A. § 50-36-1, from the Teachers Retirement System of Georgia, the undersigned applicant verifies one of the following with respect to my application for a public benefit:**

- I am a United States citizen.
- I am a legal permanent resident of the United States.
- I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency.

My alien number issued by the Department of Homeland Security or other federal immigration agency is:  
\_\_\_\_\_.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

The secure and verifiable document provided with this affidavit can best be classified as:  
\_\_\_\_\_.

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in \_\_\_\_\_ (city), \_\_\_\_\_ (state).

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Printed Name of Applicant

SUBSCRIBED AND SWORN BEFORE ME ON THIS THE \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
NOTARY PUBLIC  
My Commission Expires:



## Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

- A United States passport or passport card [O.C.G.A § 50-36-2(b)(3); 8 CFR § 274a.2].
- A United States military identification card [O.C.G.A § 50-36-2(b)(3); 8 CFR § 274a.2].
- A driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A § 50-36-2(b)(3); 8 CFR § 274a.2].
- An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A § 50-36-2(b)(3); 8 CFR § 274a.2].
- A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at <http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm>. [O.C.G.A § 50-36-2(b)(3); 8 CFR § 274a.2].
- A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A § 50-36-2(b)(3); 8 CFR § 274a.2].
- An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A § 50-36-2(b)(3); 8 CFR § 274a.2].
- A passport issued by a foreign government [O.C.G.A § 50-36-2(b)(3); 8 CFR § 274a.2].
- A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A § 50-36-2(b)(3); 8 CFR § 274a.2].
- A Free and Secure Trade (FAST) card [O.C.G.A § 50-36-2(b)(3); 22 CFR § 41.2].
- A NEXUS card [O.C.G.A § 50-36-2(b)(3); 22 CFR § 41.2].
- A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A § 50-36-2(b)(3); 22 CFR § 41.2].
- A driver's license issued by a Canadian government authority [O.C.G.A § 50-36-2(b)(3); 8 CFR § 274a.2].
- A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A § 50-36-2(b)(3); 6 CFR § 37.11].
- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A § 50-36-2(b)(3); 6 CFR § 37.11].
- In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit [O.C.G.A § 50-36-2(c)].

# Return to Work Agreement



## ▼ To Be Completed by Member -- *please print clearly*

### Member Information

Please provide the requested information.

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Social Security Number

\_\_\_\_\_

Title (Mr, Ms etc.)      Last Name      First Name      Middle Initial

(\_\_\_\_\_) \_\_\_\_\_

Phone Number (daytime)      Date of Birth (mm/dd/yyyy)      Sex (M or F)

\_\_\_\_\_

Street Address (home address)

\_\_\_\_\_

City      State      Zip Code

### Your Signature

Please sign and date verifying your adherence to Georgia Law.

Georgia law prohibits a TRS member and employer from entering into either a verbal or written employment agreement prior the member's retirement/last day of work. If it is determined that an unlawful employment agreement has been entered into by a TRS member and employer, the member's retirement will be revoked and all benefits paid to the member will be due to TRS.

***Any person who knowingly makes false statements or records to the retirement system shall be guilty of a misdemeanor.***

**By signing below, I certify that I have not entered into an agreement with any TRS employer that allows me to return to service in a TRS covered position, including service as or for an independent contractor. Any return to employment or rendering of any paid service, including service as or for an independent contractor, for any employer during the calendar month of the effective date of retirement shall render the severance invalid and nullify your application for retirement.**

\_\_\_\_\_

Your Signature

\_\_\_\_\_

Date





# Tax Forms

Please make sure you fill out all the necessary tax forms. You will need to fill out the State Tax Form (G-4P) and the Federal Tax Form (W-4P). We always provide the latest state and federal tax forms on our website at [www.TRSGA.com/forms](http://www.TRSGA.com/forms).