



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 PART II: RETIREMENT BENEFIT OPTION SELECTION AND TAX FORM PACKET. **The retirement process is not complete until you have returned the RETIREMENT BENEFIT OPTION SELECTION form in PART II.**



START TODAY

This packet includes the following documents:

- » FORM 10, TRS APPLICATION FOR RETIREMENT
- » PEEHIP INSURANCE AUTHORIZATION
- » RSA DIRECT DEPOSIT AUTHORIZATION



IMPORTANT INFORMATION

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



CONTACT US

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

- Make sure that the TRS has your current home mailing address. You can change your mailing address online at <https://mso.rsa-al.gov> or by completing the CHANGE OF ADDRESS 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 **FORM 10, TRS APPLICATION FOR RETIREMENT**. Have your employer complete the Employer Certification section.
2. Complete the **PEEHIP INSURANCE AUTHORIZATION** form. Have your employer complete the Employer Certification section. **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 **FORM 10, TRS APPLICATION FOR RETIREMENT; PEEHIP INSURANCE AUTHORIZATION**, and any other completed forms to:

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

Your **TRS 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 the month.

FREQUENTLY ASKED QUESTIONS

Q. How do I designate multiple beneficiaries?

Leave the Beneficiary Designation section on the **FORM 10** blank and submit the **MULTIPLE BENEFICIARIES ATTACHMENT, FORM 10MB**. **FORM 10MB** is only for members who select the Maximum Benefit or Option 1 on the **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, you and your physician must complete the **REPORT OF DISABILITY PACKET**. This packet must be included with your **FORM 10**. You may download the form 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 **APPLICATION FOR RETIREMENT (PART I)**, you will be sent **PART II: RETIREMENT BENEFIT OPTION SELECTION AND TAX FORM PACKET**. This packet will contain your retirement allowance report. Your **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 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. 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 **TRS APPLICATION FOR RETIREMENT** 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?

- » Visit RSA's website at www.rsa-al.gov
- » 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 Application for 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

Check One: Service Retirement Disability Retirement (*REPORT OF DISABILITY packet must also be submitted*)

Your Information

Name _____
First Middle/Maiden Last

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

Daytime Telephone _____ Email Address _____

Date of Birth _____

Retirement Information

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

Employer _____ Employer Telephone _____

Date of Retirement _____ Financial Institution Name _____
(This date is always the first of a month.) (For Direct Deposit)

Beneficiary Designation

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

Relationship to me _____ Date of Birth _____

Social Security Number _____

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.

Member Authorization

Sign Here →

Your Signature _____ 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.

Signature of Notary Public _____

Seal My Commission Expires _____

Employer Certification

To be completed by the employing agency

No contributions should be made on lump sum leave pay.

Last date of compensated employment _____

Date of Termination _____

Job Classification _____

Contract salary for full year _____

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

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

Days worked/days contracted for current contract period _____

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

Employer Signature _____ Date _____

Project/certify amount of deductions for last 7 months for which contributions will be submitted:	
Jul _____	Jan _____
Aug _____	Feb _____
Sep _____	Mar _____
Oct _____	Apr _____
Nov _____	May _____
Dec _____	Jun _____

Sign Here →



TRS Application for 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

Name _____ SSN

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Hospital Medical Information

Members currently enrolled in PEEHIP Hospital Medical coverage, check the box which applies:
I wish to continue 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 →
Member

Your Signature _____ Date _____

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 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 _____

Employer Certification

To be completed by the employing agency

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

The employee is a 9 10 11 12 month employee.

Sign Here →
Employer

Payroll Clerk/Insurance Official Signature _____ Date _____

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 date of 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 →
Member

Your Signature _____ Date _____

Non-Participating Systems

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 Plans 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.

Sign Here →
Member

Your Signature _____ Date _____

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 complete 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. Yes No

**For members enrolled in both the PEEHIP Hospital Medical coverage and one or more Optional Coverage Plans: A member cannot drop Optional Coverage Plans (Dental, Vision, Indemnity, Cancer) until Open Enrollment. Hospital Medical coverage will be dropped the first day of the month following receipt of notification. Optional Coverage Plans 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 → Representative Signature _____ Date _____
Financial Institution 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..