Plymouth County Retirement Association

Disability Retirement Application Supplemental Forms

Dear Member:

Along with your Disability Retirement Application, voluntary or involuntary, you will also need to complete and submit the Disability Retirement Application Supplemental Forms.

Please complete and return this Disability Retirement Application Supplemental Forms package along with your Disability Retirement Application, Treating Physician's Statement, medical records and a copy of your birth certificate or, if unavailable, a passport is acceptable. If after reviewing the options you decide to retire under Option C, you will also need to submit a copy of your beneficiary's birth certificate and, if the beneficiary is also your spouse, a copy of your marriage certificate.

IMPORTANT: Due to a new system set up by the Public Employee Retirement Administration Commission (PERAC), medical records need to be submitted in a specific way. For each physician or medical facility that you submit records from, a cover sheet with the name of the physician or medical facility needs to be listed on it as well as the dates the medical records cover. The medical records need to be submitted from earliest date to latest date within each set of medical records that you submit. An example of the cover sheet is on the following page. Applications, specifically medical records, submitted incorrectly may delay the processing of your application.

If you have any questions about the disability retirement application process, please contact our office to speak with a counselor or to schedule an appointment.

Sincerely,

Plymouth County Retirement Association
(508) 830 - 1803

BOSTON

MEDICAL CENTER

9/12/2015 TO 12/1/2021

SAMPLE

HOW TO SUBMIT MEDICAL RECORDS
(You need to submit a cover sheet like this for each physician or medical facility's medical records that you submit with your application.)

Plymouth County Retirement Association
Disability Retirement Application Supplemental Forms

Section 1 – Member Information

Name____ **SS#** XXX - XX - ________
(First) (M.I.) (Last)

Address____

City__________________________________ **State**__________ **Zip Code**____________

Home Phone (______) _______ - __________ **Cell Phone** (______) _______ - __________

E-Mail address________________________________ **Date of Birth**_____/_____/_______

Marital Status: ☐ **Single** ☐ **Married*** ☐ **Divorced** ☐ **Widowed**

*If married, spouse's full name___________________________________

If you have ever been divorced, do you have a qualified Domestic Relations Order (DRO) in effect? ☐ **No** ☐ **Yes***

* If yes, please forward a copy of your Domestic Relations Order (DRO) with your application.

Veteran Status: ☐ **No** ☐ **Yes** (If yes, please include a copy of your DD-214)

Disability Applied For: ☐ **Accidental** ☐ **Ordinary** ☐ **Both Accidental and Ordinary**
☐ **An Involuntary Disability was submitted by my employer**

Section 2 – Dependent Information

Do you have any children under the age of 18, between the ages of 18 - 22 who are full time students or over 18 years of age and who are physically or mentally incapacitated from earning? ☐ **No** ☐ **Yes***

*If yes, please name **and** provide a certified copy of their birth certificate.

Name	Social Security Number	Under 18	18 - 22	Incapacitated
______________________	_____ - ____ - _______	☐	☐	☐
______________________	_____ - ____ - _______	☐	☐	☐
______________________	_____ - ____ - _______	☐	☐	☐

Applicant's Signature____________________________________ **Date**______________

OPTION SELECTION FORM – (CHECK ONE)

☐ **Option A**

Option A provides the highest monthly benefit allowance that you are eligible for, but it does not provide any survivor benefits. Your benefits would stop effectively on your date of passing and, if any benefits are due for the pro-rated month of your passing, they will be paid in a lump sum payment to your named beneficiary/ies that you have listed.

☐ **Option B**

Option B pays a monthly allowance approximately 1 - 2 percent less than Option A. At the time of your passing, it provides for a one-time lump sum payment of any funds left in your annuity savings fund, if any, to your named beneficiary/ies that you have listed. These funds generally run out between 9 - 11 years into retirement, at which time there would be no funds for a beneficiary/ies.

☐ **Option C**

Option C pays a monthly allowance approximately 9 - 11 percent less than Option A. At the time of your passing, it provides a continuous monthly survivor benefit of 2/3 of what your monthly benefit is at the time of death. You can only name one Option C beneficiary and cannot change that beneficiary after the date of your retirement. If your beneficiary predeceases you, you will be popped up to your Option A allowance.

Option C Beneficiary (Name) ____
Beneficiary Date of Birth ______/______/________ **SS#**________- ______- ________
Relationship to you*____
* The relationship is limited to spouse, former spouse not remarried, parent, sibling, child.

I have read and understand the provisions of **Option** ☐ that I have selected above.

Applicant's Signature ____ **Date**__________

Witness Signature (Required)
If you are married, the witness must be your spouse. Witness cannot be a beneficiary unless the beneficiary is your spouse.

Witness Signature____ **Date**__________

Print Name____

Address____

BENEFICIARY INFORMATION

Please complete this section if you are retiring under Option A or Option B only. If you are retiring under Option C, please complete the beneficiary section on page 2 of the application. You may change your beneficiary/ies at any time by completing a new beneficiary form. If you need more space for additional beneficiaries, please make a photocopy of this page and fill in the information.

Name____ **Percentage** ______%

Address____

City_________________________________ **State**__________ **Zip Code**___________

Relationship______________ **Date of Birth**____/____/______ **SS#**____-____-_____

Name____ **Percentage** ______%

Address____

City_________________________________ **State**__________ **Zip Code**___________

Relationship______________ **Date of Birth**____/____/______ **SS#**____-____-_____

Name____ **Percentage** ______%

Address____

City_________________________________ **State**__________ **Zip Code**___________

Relationship______________ **Date of Birth**____/____/______ **SS#**____-____-_____

Name____ **Percentage** ______%

Address____

City_________________________________ **State**__________ **Zip Code**___________

Relationship______________ **Date of Birth**____/____/______ **SS#**____-____-_____

The total of all the percentages above must equal 100%.

SUBSTITUTE W-4P TAX FORM – DISABILITY

Your monthly retirement allowance is taxable on the federal level (accidental disability on the annuity portion only, ordinary disability on both the annuity and pension portion) and as long as you live in Massachusetts, or one of fifteen other states, it is not taxable on the state level. Use this form to indicate how you would like your federal tax withheld. How you indicate you would like your federal tax withheld will remain in effect until you change it with the Plymouth County Retirement Association by completing a new Substitute W-4P Tax Form. If you do not fill out this form, the automatic default federal tax withholding would be married with three exemptions.

Name____ **SS#** XXX - XX - ________

Address____

City______________________________ **State**_____________ **Zip Code**___________

Home Phone (_____) ______ - __________ **Cell Phone** (_____) ______ - __________

PLEASE CHECK ONE ONLY

☐ I do **not** want any federal income taxes to be withheld from my check. If elected, I acknowledge that I am responsible for payment of estimated taxes and may be subject to tax penalties under the IRS's estimated tax rules.

☐ I want federal income taxes withheld based on the IRS tax tables and the marital status and the number of exemptions claimed. I understand that the amount of taxes may change if the IRS tax tables are adjusted. Please complete the rest of this section.

☐ **Single** ☐ **Married** ☐ **Married, but withhold at a higher single rate**

Number of exemptions claimed ☐

Additional amount to be withheld (if any) $______________

☐ I want my federal income taxes withheld in a flat amount per month $______________

Applicant's Signature___________________________________ **Date**______________

DIRECT DEPOSIT AUTHORIZATION FORM

Your first payment will be made to you via a check in the mail then all future payments will be via direct deposit on the last business day of each month. Direct deposit statements will only be mailed to you when there is a change in the amount of your deposit from the previous month. If you wish to change which bank and/or account you would like to have your monthly retirement allowance go to, please complete a new Direct Deposit Authorization Form.

Section 1 – Member Information

Name____ **SS#** XXX - XX - _________

Address____

City__________________________________ **State**___________ **Zip Code**_____________

Home Phone (______) _______ - ___________ **Cell Phone** (______) _______ - ___________

Section 2 – Bank Information

Name of Financial Institution____

All names on account____

Routing# ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Account # ____

☐ **Savings account** ☐ **Checking account (please also attach a blank voided check)**

Is your direct deposit going to a foreign bank directly or forwarded to a foreign account from a domestic bank? ☐ **No** ☐ **Yes**

I hereby authorize the Plymouth County Retirement Association (PCRA) to electronically deposit my monthly retirement allowance to the bank and account number as stated above. The PCRA is also authorized to make any adjustments, debit or credit, as a result of errors in transfer. This authorization is to remain in full force and in effect until revoked by me in writing to the PCRA.

Applicant's Signature_______________________________________ **Date**______________

INSURANCE PREMIUM AUTHORIZATION FORM - DISABILITY

Choose One

☐ I, ________________________________, hereby certify that I have filed, or intend to file, a disability retirement application with the Plymouth County Retirement Association from my service from __________________________________ with my date of retirement TBD and I
(County, Town, Housing Authority, District or Agency)
request to continue to have the applicable portion of my insurance coverage deducted directly from my monthly retirement allowance. I fully understand that:

- Until the appropriate premium has been withheld from my monthly retirement allowance, as authorized below, I shall make direct payments to the Treasurer of the county, city/town, housing authority or agency from which I retire.
- If I cancel the aforementioned coverage and wish to reinstate it at some future date, I will not be able to do so until an open enrollment period or other qualifying event.
- Upon any change of status or dependents insured under my coverage, such information must be submitted in letter form to the Treasurer of the county, city/town, housing authority or agency from which I retire.
- I agree to be liable for any change in the premium based on a change in the contract.
- The hospital/medical/surgical benefits will remain at the same level as that provided for all county, city/town, housing authority or agency employees.
- My life insurance coverage upon retirement will be in accordance with the policy of the county, city/town, housing authority or agency from which I have retired.

☐ I, ________________________________, hereby certify that I have filed, or intend to file, a disability retirement application with the Plymouth County Retirement Association from my service from __________________________________ with my date of retirement TBD and I do
(County, Town, Housing Authority, District or Agency)
not intend to continue with insurance from my former employer. I acknowledge that I have contacted my former employer about my eligibility to pick up said coverage in the future if I so need to.

I hereby authorize the county, city/town, housing authority or agency to withhold the premium for coverage, if noted above, from my monthly retirement allowance, such sum to be paid to the carrier of my premium for the month following the month covered by the monthly retirement allowance check from which said deduction is made. Otherwise, I acknowledge that no insurance premium will be withheld.

Applicant's Signature______________________________________ **Date**_______________

BEFORE YOU SUBMIT YOUR DISABILITY RETIREMENT APPLICATION

Before you submit your Disability Retirement Application, please review to make sure you have fully completed all of the enclosed pages and provided any additional documents to avoid any delays in processing your retirement including:

- ☐ A copy of all your medical records with the cover sheet for each physician or medical facility submitted as shown by example in the beginning of this Disability Retirement Application Supplemental Forms package.
- ☐ Separate Disability Retirement Application with applicant's signature on pages 3, 14 and 16.
- ☐ Separate Treating Physician's Statement.
- ☐ Applicant's signature on pages 1, 2, 4, 5 and 6 of this Disability Retirement Application Supplemental Form package.
- ☐ Witness signature on page 2 of this Disability Retirement Application Supplemental Forms package. The witness must be your spouse if you are married.
- ☐ If you are retiring under Option C, your beneficiary's birth certificate and, if the beneficiary is your spouse, a copy of your marriage certificate.
- ☐ A blank voided check if your required direct deposit is going into a checking account.
- ☐ A copy of your DD-214 if you are a veteran
- ☐ If applicable, a copy of any QDROs.
- ☐ A copy of any dependents' birth certificate that you listed in Section 2 of page 1 of this Disability Retirement Application Supplemental Forms package.

If you have any questions in regards to your disability retirement application, please feel free to contact our office at (508) 830 - 1803 to speak with a counselor or to schedule an appointment.

WORKING POST DISABILITY RETIREMENT

If you are approved for a disability retirement, accidental or ordinary, you are eligible to earn additional money during the course of your retirement. However, there are limitations to what you can earn in a calendar year whether it is in public or private employment. Please use the following chart to calculate earnings, pursuant to M.G.L. c. 32, § 91A.

Calculation for Calendar Year: ________________

Position from which you retired ______________________________

"Regular Compensation" for that position. $______________________________
(Salary you would be earning if you were still working)
(Obtained from your former employer)

+

Additional amount allowed under statute $__________$15,000.00___________

=

Sub Total $______________________________

-

Subtract total amount of Retirement Allowance you are receiving. (Pension + Annuity) $______________________________

=

This is the amount you are allowed to earn. $______________________________

In addition to the compensation limits, disability retirees are also limited in public sector post retirement by the total amount of hours they can work in a calendar year. No retiree is allowed to work in excess of 1,200 hours combined between all public sector employments if they are working for more than one public employer. Anything beyond this hourly limit would be considered excess earnings. If you reach either the dollar allowance or the hour limit before the other, you will be considered an over earner if you never reach the other.

Disclaimer: This sheet is being provided to you for informational purpose only so that you are aware of the post-retirement earnings restrictions. If you exceed your allowable earnings amount, you must refund the excess amount back to the Plymouth County Retirement Association.

Plymouth County Retirement Association

60 Industrial Park Road

Plymouth, MA 02360