

TRS RETIREMENT APPLICATION

**TO ALLOW TIMELY PROCESSING OF YOUR RETIREMENT APPLICATION,
ALL AREAS OF THE APPLICATION FORM MUST BE COMPLETED.
FAILURE TO COMPLETE THE APPLICATION WILL DELAY THE PROCESSING
OF YOUR APPLICATION AND THE PAYMENT OF YOUR BENEFIT.**

This packet includes a retirement application form. Please complete the form in its entirety and return it to the Division of Retirement and Benefits.

- Incomplete forms will cause a delay in the process of your benefits. You must sign the application on page F-10.
- The application form must be received by the Division or postmarked no later than the last day of the month prior to your desired retirement effective date.
- To avoid delays in health coverage reporting, we request you file your application 60 days prior to your retirement effective date.
- All retirement effective dates for eligible retirees are the first of the month following termination of employment **and** receipt of the retirement application. **If you have served a full school year this year, your effective date for retirement is July 1 if your retirement application is received before that date. Health insurance coverage is effective on the date of your retirement if you enroll in the plans and the required premiums are paid either by direct deduction from your retirement check or self-payment to the health plan.**

If you need assistance in completing the forms, please contact your regional retirement counselor toll-free at (800) 821-2251 or in Juneau (907) 465-4460.

IMPORTANT NOTICE! When your retirement application has been processed, you will receive a letter from the Division summarizing your elections. Please read this letter carefully and report any discrepancies between the letter and your intended elections immediately. Corrections to your elections can only be made within 15 days of the date of the letter or before your next benefit check is issued, whichever is later.

FIRST RETIREMENT CHECK

Pension benefits are paid at the end of each month. **The processing of your first benefit check can take approximately six weeks from your retirement effective date.** Once your application has been processed, benefit checks will be automatically issued at the end of each month.

If you have elected electronic direct deposit, your checks will be electronically deposited into your bank account once the pre-notification process has been completed. The pre-notification process typically occurs around the 13th of each month. Please be aware that if we are unable to process your retirement before the pre-notification process, your first benefit check may be delivered to your mailing address. Each month your check is direct-deposited, you will receive a detailed accounting of the deposit called a “warrant advice.”

If you have not elected electronic direct deposit, your checks will be mailed to your correspondence address.

Pull this application form out from the center of the booklet and mail your completed form to:

**Alaska Teachers' Retirement System
Division of Retirement and Benefits
P.O. Box 110203
Juneau, AK 99811-0203**

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TRS RETIREMENT APPLICATION INSTRUCTIONS

To allow timely processing of your retirement application, all areas of the application form must be completed. We have included this instruction sheet to assist you. If you have any questions regarding the benefits you are electing on the application form, please contact the Division of Retirement and Benefits at (800) 821-2251 and speak to a counselor.

- I. Employee Information.** Your Retirement Identification Number (RIN) can be found on your annual statements. Be sure to include a contact telephone number or your email address so processing staff can reach you if there is any problem with the processing of your application once verification of your service has been received.
- II. Pension Benefit Election.** Refer to page 22 for an overview of the benefit options. If you are married, you must elect a survivor option unless your spouse waives continuing benefits in the event of your death. In Section A, you will complete the information regarding your survivor or qualified same-sex partner and choose the level of continuing survivor benefits you wish to provide. **If you are electing a same-sex partner, please also complete the Retiree Same-Sex Partner Affidavit and the Declaration of Tax Status-Alaska Benefit Plans form on pages 35-38 of this booklet.**

To elect an incapacitated dependent child as your survivor, you must 1) be eligible to select survivor benefits by being married or have a qualified same-sex partner, 2) your spouse or same-sex partner must waive their right to benefits, 3) submit medical documentation substantiating incapacity and dependency with this application for approval by the Administrator. Approval by the TRS Administrator is required if you select a beneficiary for survivor benefits other than your spouse or qualified same-sex partner.

If you are single, you must choose a benefit option from Section B. If you are married and wish to make an election from Section B, you must have your spouse waive their right to a survivor benefit. **Once waived, all benefits, including medical insurance, cease at your death if you choose no survivor option.** The waiver can be witnessed by a Division of Retirement and Benefits representative, a notary or a postmaster.

- III. Indebtedness Payment.** If you have an outstanding indebtedness for service that makes you eligible for retirement, you must make final payment prior to retirement. For service not used for eligibility, you must elect whether to make final payment prior to retirement or to take a lifetime actuarial reduction to your retirement benefit. If you plan on paying your indebtedness with a pre-tax transfer, you must initiate the request six weeks in advance of your scheduled retirement date. The indebtedness must be paid prior to your retirement date. **Please note: An indebtedness for refunded and reinstated service cannot be paid by a pre-tax transfer. Statutes allowing for a pre-tax payment of this type of indebtedness were repealed on July 1, 2010.**
- IV. Application for Alaska Cost-of-Living Allowance (COLA).** Please see page 27 of this retirement booklet for eligibility information regarding the COLA. Be sure to enter your physical address. COLA benefits cannot begin until a physical address is submitted. It is your responsibility to ensure you are eligible to receive this benefit. If you are determined to be ineligible at any time, any overpayment of COLA must be repaid to the system.
- V. Electronic Direct Deposit Authorization.** Complete this section if you want your benefit electronically deposited directly to your financial institution. **You must attach a voided check (or deposit slip if depositing to a savings account) in the specified area.** If you are depositing to an out-of-state bank, please confirm they will accept an electronic deposit. **Due to federal regulations, we cannot transfer funds electronically if the funds will be forwarded to an account in another country.**
- VI. Unused Sick Leave Credit.** Be sure to send the Supplemental Claim form to your employer for verification. (The form is located in the Appendix.) **It is your responsibility to ensure your employer completes the form and submits it to the Division within one year of your retirement date.** Alaska Statute prohibits the crediting of unused sick leave claims received more than one year after your retirement date.
- VII. Health Benefit Enrollment.** For basic information about the medical, Dental-Vision-Audio (DVA) and Long-Term Care (LTC) insurance available to retirees, please see pages 9-21. Enroll in Medical, DVA and/or LTC in this section for yourself and eligible dependents. **This may be your only opportunity to enroll.**

- VIII. Retiree Health Dependent Enrollment.** Enroll your eligible dependents (spouse, qualified same-sex partner, and dependent child[ren]) with the health plan. **Claims for dependents cannot be processed without this information.** Please see pages 9-10 for the definition of eligible dependent.
- IX. TRS Beneficiary Designation.** Designate who is to receive your last retirement check and the balance of your contribution account, if any, at the time of your death. If you elect a survivor benefit, your beneficiary is automatically your spouse or your qualified same-sex partner. Your spouse may waive their rights in favor of another beneficiary who would receive only your last check.
- X. Optional Life Enrollment.** If you are a State of Alaska employee, or an employee with a TRS employer that participates in the State of Alaska Optional Life Plan and you were participating in the plan at the time of your separation of employment, you may elect to continue this coverage. Be sure to complete the beneficiary designation for this benefit.
- XI. Tax Withholding Election.** If no election is designated, a default of married with three allowances will be used. If you are unsure of your appropriate election, please consult with your tax professional.
- XII. Court Certified Copies of Divorce/Dissolution Documents.** A court certified copy is a copy that has been copied by the clerk of the court and contains an **original** certification stamp. If you have been married and divorced during your TRS employment, a portion of your benefit may be viewed as marital property under federal law. **Your retirement application cannot be processed without a court certified copy of your divorce/dissolution to establish what, if any, entitlement a former spouse may have to your benefit.**
- XIII. Certification.** Please read this section carefully. Some of the benefit options you elect are irrevocable. Be sure you understand your options before you sign and submit this application. If you have any questions, please contact the Division and ask to speak to a retirement counselor.

ADDITIONAL FORMS FOR SAME-SEX PARTNER, IF APPLICABLE

Same-Sex Partner Affidavit

Declaration of Tax Status

TRS Application for Retirement Benefits

I. EMPLOYEE INFORMATION

NAME (FIRST, MI, LAST)		(FORMER)	SOCIAL SECURITY NUMBER OR RIN	WORK/HOME TELEPHONE ()
BIRTH DATE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> SAME-SEX PARTNER		DATE OF MARRIAGE
MAILING ADDRESS (STREET OR P.O. BOX, CITY, STATE, ZIP+4)			E-MAIL ADDRESS	

II. PENSION BENEFIT ELECTION

I hereby apply for Early Normal retirement benefits to become effective the 1st day of _____ (month), _____ (year).

*If you have worked 172 days in this school year, your retirement effective date is July 1.

Retirement Options. Choose from either A or B below.

A. Survivor Options (Married members or members with same-sex partners)

____ I have contributed to the 1% supplemental contribution program and I am entitled to continuing survivor benefits.

____ I have not participated in the 1% supplemental contribution program and elect the survivor benefit I have checked below.

Survivor Information

Name (First, MI, Last) _____ Date of birth _____

Social Security Number: _____ Relationship Spouse Same-Sex Partner

If electing a same-sex partner relationship, both you and your partner must complete and sign the *Same-Sex Partner Affidavit and the Declaration of Tax Status* forms and submit them with this application. Documentation supporting the affidavit need not be filed with the application but is required before benefits can be paid. (See page 22 for information about designating an incapacitated child as your survivor.)

If you are married, you must choose one of the following options to receive a survivor benefit:

I elect: 75% Joint Survivor Option 50% Joint Survivor Option

66-2/3% Last Survivor Option

In selecting the 66-2/3% Last Survivor Option, I understand if my spouse or qualified same-sex partner dies first, my benefit will be reduced to 66-2/3% for the rest of my life. If I die first, my spouse or qualified same-sex partner will receive the 66-2/3% survivor benefit for the rest of his/her life.

B. No Survivor Option (Single members. If you are married you may only choose this option if your spouse signs the waiver below.)

All benefits including medical coverage will cease upon the death of the applicant.)

Normal or Early Benefit: I do not elect a Survivor Option.

SPOUSE'S WAIVER OF SURVIVOR OPTION

(Complete only if married and NOT selecting a survivor option.)

I acknowledge and approve the benefit selected. I understand the terms of the selection and that by signing this waiver I **freely waive entitlement to continuing survivor benefits, including health coverage**, which may otherwise be payable to me, upon the death of the named applicant.

SPOUSE'S SIGNATURE _____ PRINTED NAME _____ DATE _____

Spouse's signature witnessed by _____
DIVISION OF RETIREMENT AND BENEFITS REPRESENTATIVE, NOTARY PUBLIC OR POSTMASTER

On this _____ day of _____, 20____, personally appeared before me _____ whose identity I proved on the basis of satisfactory evidence to be the signer of the participant signature above, and he/she acknowledged that he/she executed it.

Notary Public: _____

State of: _____ and Borough/County of: _____

Residing at: _____ Commission Expires: _____

SEAL OR
POSTMASTER STAMP
REQUIRED

III. INDEBTEDNESS PAYMENT I HAVE NO INDEBTEDNESSI hereby **irrevocably** elect:

- to pay my indebtedness in full prior to my retirement effective date.
- by check
- to pay my indebtedness by a pre-tax plan transfer (**must initiate request for transfer prior to retirement**)
- to cancel any outstanding indebtedness due by accepting an actuarial reduction to my retirement benefit for life.
- Option I (benefits withheld until indebtedness paid—only for members who first entered before July 1, 1982)

IV. APPLICATION FOR ALASKA COST-OF-LIVING ALLOWANCE (See page 27 for eligibility requirements.)

- I wish to receive Alaska Cost-of-Living Allowance (COLA) payments to be effective the date of my appointment to retirement. I understand, for the purposes of AS 14.25.142, in order to be entitled to receive this cost-of-living allowance, I **must have first entered TRS before July 1, 1990**, or be age 65 if first entered after June 30, 1990, and must be **domiciled** and **physically present** in the State of Alaska. Further, I understand a standard legal definition of domicile is: "That place where a person has his or her true, fixed and permanent home and principal establishment, and to which whenever absent, has the intention of returning." I will notify the TRS whenever I plan to leave Alaska for a continuous period exceeding **90 days** or when I have been out of Alaska for more than **90 days**. I understand if I am gone for 91 days or more, COLA will **not** be paid for the entire absence. I understand I am required to repay any overpayments to the Division of Retirement and Benefits for COLA received during any ineligible periods.

Physical Residence Address (not a P.O. Box) _____

V. ELECTRONIC DIRECT DEPOSIT AUTHORIZATION

Complete the Electronic Direct Deposit Authorization if you want your benefit electronically deposited directly to your financial institution. **NOTE:** If you do not elect the direct deposit program, your warrant will be mailed to your correspondence address.

- I do not elect electronic deposit.
- I hereby authorize the State of Alaska to make net payroll warrant deposits to my account as indicated below:
- CHECK ONE: Savings Checking Bank Routing Number _____
- Account Number _____

FINANCIAL INSTITUTION _____

ATTACH A VOIDED CHECK HERE
(used to verify your bank transit routing and account number)

By completing this section, I also authorize the State of Alaska, if necessary, to make adjustments to the above account to correct any credit entries made in error. I understand the State will make a reasonable effort to notify me within twenty-four (24) hours when an adjustment is made. This authority remains in effect as long as I am retired or until the State receives written notice from me. I understand that 30 days written notice is required to change financial institutions, account numbers, or type of account. I further understand direct deposit will begin **after** the above account information has been electronically verified.

I also understand that **unless** I inform the Division of Retirement and Benefits otherwise, the first payroll after such changes are made, my benefit will be **electronically deposited** to the previous financial institution. Changes do not take effect until the second payroll after the change was initiated.

Direct deposit is not available to financial institutions in foreign countries. **Due to federal regulations, funds cannot be transferred electronically if the fund will be forwarded to an account in another country.**

VI. UNUSED SICK LEAVE CREDIT

You may be eligible to receive additional TRS credit by claiming your unused sick leave. To claim your unused sick leave, submit the *Claim and Verification of Unused Sick Leave* form found at the back of this instruction booklet to your last TRS employer for verification.

To receive additional credit, the completed verification form must be received by the TRS within one year of your retirement effective date. It is your responsibility to ensure this form is completed and returned to the Division of Retirement and Benefits.

Name _____

Social Security Number or RIN _____

Retirement Effective Date _____

VII. HEALTH BENEFIT ENROLLMENT

MEDICAL BENEFITS (must mark a box)

Premium Payment Required - See Premium Rate Card

I elect the following **medical** coverage: **No medical coverage**

Retiree only

Retiree and spouse or same-sex partner

Retiree and child(ren)

Retiree, spouse or same-sex partner, and child(ren) System-paid AlaskaCare medical (see pages 9-12 for eligibility requirements)

DENTAL-VISION-AUDIO BENEFITS (must mark a box)

Premium Payment Required - See Premium Rate Card

I elect the following **Dental-Vision-Audio (DVA)** coverage: **No Dental-Vision-Audio coverage**

Retiree only

Retiree and spouse or same-sex partner

Retiree and child(ren)

Retiree, spouse or same-sex partner, and child(ren)

LONG-TERM CARE BENEFITS (must mark a box)

Premium Payment Required - See Premium Rate Card

I elect the following **Long-Term Care (LTC)** option:

Retiree coverage:

No Long-Term Care coverage

Silver

Gold

Platinum

I am covered under my spouse's LTC plan. Spouse's SSN _____

Spouse or same-sex partner coverage (may only elect if member is electing coverage):

No Long-Term Care coverage

Silver

Gold

Platinum

Spouse's date of birth _____

VIII. RETIREE HEALTH DEPENDENT ENROLLMENT FOR SPOUSE OR QUALIFIED SAME SEX PARTNER AND CHILDREN

DEPENDENT INFORMATION

I HAVE NO ELIGIBLE DEPENDENTS

MY ELIGIBLE DEPENDENTS ARE LISTED BELOW (see pages 9-10)
(Attach additional sheets if necessary)

1. Dependent Last Name, First, M.I.

Social Security Number

Date of Birth

Relationship

Spouse

Date of Marriage _____

Same-Sex Partner

Other

Male

Female

Full-Time Student

No

Yes

Mailing Address (City, State, ZIP+4)—if different from retiree's

2. Dependent Last Name, First, M.I.

Social Security Number

Date of Birth

Relationship

Spouse

Date of Marriage _____

Same-Sex Partner

Other

Male

Female

Full-Time Student

No

Yes

Mailing Address (City, State, ZIP+4)—if different from retiree's

3. Dependent Last Name, First, M.I.

Social Security Number

Date of Birth

Relationship

Spouse

Date of Marriage _____

Same-Sex Partner

Other

Male

Female

Full-Time Student

No

Yes

Mailing Address (City, State, ZIP+4)—if different from retiree's

4. Dependent Last Name, First, M.I.

Social Security Number

Date of Birth

Relationship

Spouse

Date of Marriage _____

Same-Sex Partner

Other

Male

Female

Full-Time Student

No

Yes

Mailing Address (City, State, ZIP+4)—if different from retiree's

IX. TRS BENEFICIARY DESIGNATION

If you are **MARRIED**, your spouse is automatically your 100% primary beneficiary unless they consent to another beneficiary, or your spouse is not entitled to benefits under the terms of a Qualified Domestic Relations Order (QDRO). Please complete the spousal consent to an Alternate Benefit form, Appendix 1, if your spouse is waiving entitlement to benefits. Your spouse's written consent may be waived if:

- You were not married to your spouse during part of your TRS employment;
- You have been married for less than two years and you have established that you and your spouse are not living together;
- Your spouse cannot be located.

PRIMARY BENEFICIARIES

1. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
--------------	------------------------	------------------------	---------------	------------

Mailing Address (City, State, ZIP+4)

2. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
--------------	------------------------	------------------------	---------------	------------

Mailing Address (City, State, ZIP+4)

3. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
--------------	------------------------	------------------------	---------------	------------

Mailing Address (City, State, ZIP+4)

4. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
--------------	------------------------	------------------------	---------------	------------

Mailing Address (City, State, ZIP+4)

SECONDARY BENEFICIARIES (Beneficiary in the event the primary beneficiary is no longer living.)

1. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
--------------	------------------------	------------------------	---------------	------------

Mailing Address (City, State, ZIP+4)

2. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
--------------	------------------------	------------------------	---------------	------------

Mailing Address (City, State, ZIP+4)

3. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
--------------	------------------------	------------------------	---------------	------------

Mailing Address (City, State, ZIP+4)

4. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
--------------	------------------------	------------------------	---------------	------------

Mailing Address (City, State, ZIP+4)

5. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
--------------	------------------------	------------------------	---------------	------------

Mailing Address (City, State, ZIP+4)

X. OPTIONAL LIFE ENROLLMENT

Please verify eligibility with your human resource office before completing. Only those State of Alaska and political subdivision employees currently participating in a State-sponsored optional life plan are eligible to enroll.

I do **not** elect to continue my Optional Life Insurance and hereby waive my right to participate now and in the future.

I elect to continue my Optional Life Insurance and hereby authorize the State to make the necessary deduction from my benefit check. (*Complete beneficiary designation.*)

Life Insurance Volume Amount \$ _____ Premium \$ _____

PRIMARY BENEFICIARIES

1. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
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Mailing Address (City, State, ZIP+4)

2. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
--------------	------------------------	------------------------	---------------	------------

Mailing Address (City, State, ZIP+4)

3. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
--------------	------------------------	------------------------	---------------	------------

Mailing Address (City, State, ZIP+4)

4. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
--------------	------------------------	------------------------	---------------	------------

Mailing Address (City, State, ZIP+4)

SECONDARY BENEFICIARIES (Beneficiary in the event the primary beneficiary is no longer living.)

1. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
--------------	------------------------	------------------------	---------------	------------

Mailing Address (City, State, ZIP+4)

2. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
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Mailing Address (City, State, ZIP+4)

3. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
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Mailing Address (City, State, ZIP+4)

4. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
--------------	------------------------	------------------------	---------------	------------

Mailing Address (City, State, ZIP+4)

5. Full Name	Relationship to Member	Social Security Number	Date of Birth	Percentage
--------------	------------------------	------------------------	---------------	------------

Mailing Address (City, State, ZIP+4)

XI. TAX WITHHOLDING ELECTION

Federal Tax Information: See the Withholding Certificate for Pension or Annuity Payments (W4-P) Personal Allowance Worksheet or your tax professional for more information on the amount of taxes you should have withheld.

Check here if you want **NO** federal income tax withheld from your benefit **OR** select from the following:

Married Single Married / withholding at the higher single rate

Select your desired Federal Withholding by inputting the number of allowances you are claiming in the box to the left.

\$ Additional amount of federal tax you would like withheld from your monthly benefit check (if any). Please enter as a positive amount in the box to the left.

XII. COURT CERTIFIED COPIES OF DIVORCE/DISSOLUTION DOCUMENTS

DIVORCE: If you have been married and divorced at any time during your TRS service you are **required** to submit court certified copies of your divorce decree and property settlement or dissolution of marriage. Federal law prohibits the disbursement of retirement funds unless the ex-spouse has either filed a qualified domestic relations order, has waived their right to benefits, or if there is clear evidence there is no entitlement.

XIII. CERTIFICATION

I understand that all terms of the pension benefit selected are irrevocable and that any change to my selection on this application or its withdrawal must be done in writing and received by the Division of Retirement and Benefits prior to the effective date of my benefit.

I acknowledge that I can contact the Division of Retirement and Benefits for counseling on any of my retirement options.

I acknowledge that I have been offered all three health plans available: medical, dental-vision-audio (DVA), and long-term care (LTC). I further understand that this is my only opportunity to enroll in the long-term care plan and that by not electing long-term care at this time, or by not paying the required premium payment, I waive my right to future participation in the LTC plan.

I understand that if I first entered the TRS on or before June 30, 1990, this is my only opportunity to enroll in the dental-vision-audio plan and, that by not electing DVA at this time, I waive my right to future participation in the DVA plan.

I understand that if I first entered the TRS on or after July 1, 1990, I may enroll in the medical and dental-vision-audio plans now or during an open enrollment period, subject to certain restrictions and by not paying the required premium payment.

I authorize the deduction of premiums from my benefit check for any insurance elected above.

I attest, as required by the Federal Office of Foreign Asset Control in support of U.S.C. Title 50, War and National Defense, the full amount of my direct deposit (if selected) is not being forwarded to a bank in another country and if at any point I establish a standing order with my receiving bank to forward the full direct deposit to a bank in another country, I will inform the State of Alaska, Division of Retirement and Benefits immediately. If the State discovers the full amount of a direct deposit has been forwarded to another country, the direct deposit agreement shall be terminated.

In completing this application, I acknowledge that a person who knowingly makes a false statement, or falsifies or permits to be falsified, a record of the retirement system in an attempt to defraud the system, is guilty of a class A misdemeanor, which, upon conviction, is punishable by a fine of not more than \$500.00 or by imprisonment for not more than twelve months or both. AS 14.25.210; AS 11.56.210. I also acknowledge that a person who obtains funds by deception may be subject to prosecution for other crimes, including theft, which may be charged as misdemeanors or felonies with potential fines and penalties including imprisonment. I also acknowledge that a person who obtains benefits from the system unlawfully may also be required to make restitution.

Signature _____

Date _____

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