

MEMBERSHIP FORM

PLEASE PRINT

INTERSYSTEM TRANSFER

U2 TRANSFER

M F

() -

Name

Sex

Marital Status

Home Phone Number

Social Security Number

Birth Date

Email Address

ADDRESS:

(Street)

(Apt No.)

(City)

(State) (Zip)

Name of Spouse

Spouse's Birth Date

Number of Children Under Age 18

PREVIOUS EMPLOYMENT:

1. If you were previously employed in a position that was a designated position under the Corrections Officer Retirement Plan, please complete this section:

FROM

THROUGH

TITLE OF POSITION

EMPLOYER

A. _____

B. _____

2. If you indicated that you were previously employed, was a refund issued? Circle YES or NO and initial: _____

3. **A refund will NOT be issued while you are employed with the same/ or another CORP employer. Please Complete Form C1A, "Request for Transfer" and attach it to this form.**

I declare under penalty of perjury that the above information is true, correct and complete, to the best of my knowledge and belief.

DATE: _____ EMPLOYEE'S SIGNATURE: _____

EMPLOYER ACKNOWLEDGMENT

EMPLOYER: (CHECK ONLY ONE)

DEPARTMENT OF CORRECTIONS: _____ INSTITUTION OR FACILITY: _____

DEPARTMENT OF JUVENILE CORRECTIONS: _____ INSTITUTION OR FACILITY: _____

COUNTY/CITY/TOWN OF: _____

AOC (JUDICIARY, PROBATION, SURVEILLANCE, AND JUVENILE DETENTION OFFICERS): _____ COUNTY

_____/_____/_____
Membership Date (with current employer) Position or Classification \$ Current Annual Salary

I hereby acknowledge that this person is a full time (40+ hours) employee and the Membership Date and Position or Classification information provided above corresponds with the information in our personnel files.

Date Telephone Number Authorized Signature of Employer

SIGNEE TITLE: _____ E-MAIL ADDRESS: _____

PLEASE PROVIDE A COPY OF THE MEMBER'S SOCIAL SECURITY CARD

BENEFICIARY DESIGNATION

NAME: _____ SSN: _____

In the event of my death, **and after any survivor pension payable from the Plan has terminated**, I direct that my accumulated contributions arising from deductions made from my salaries, in excess of pension payments paid to me or to a survivor,

be paid to: _____
Name(s) of **Primary** Refund Beneficiary(ies)

whose relationship(s) to me is (are): _____

if living, otherwise to: _____
Name(s) of **Contingent** Refund Beneficiary(ies)

whose relationship(s) to me is (are): _____

and whose date(s) of birth is (are): _____

if living, otherwise to my nearest of kin as determined by the Local Retirement Board. It is agreed that if more than one primary or contingent beneficiary, as the case may be, is named, my said accumulated contributions, if payable, will be paid in equal shares to the survivors, unless otherwise noted.

DATED IN _____, ARIZONA, on this _____ day of _____, _____
(city or town)

SIGNATURE OF EMPLOYEE

NAME OF WITNESS-PRINTED

SIGNATURE OF WITNESS

(Witness must be persons other than beneficiaries named above)

When completed, mail to: Corrections Officer Retirement Plan
3010 E. Camelback Rd., Suite 200
Phoenix, Arizona 85016

When Completed
Return to:

CORRECTIONS OFFICER RETIREMENT PLAN
3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016
(602)255-5575 FAX (602)296-2368 www.psprs.com

FORM C1A
08/11
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APPLICATION TO TRANSFER SERVICE CREDITS BETWEEN CORP EMPLOYERS
(A.R.S. Section 38-908)

PLEASE PRINT

MEMBER'S NAME: _____

SOCIAL SECURITY NUMBER: _____ BIRTH DATE: _____

CURRENT EMPLOYER: _____ **SYS#** _____

PREVIOUS EMPLOYER: _____ **SYS#** _____

TO BE COMPLETED BY CURRENT EMPLOYER:

I hereby certify that to the best of my knowledge and belief the statements made below are full, true and correct, and reflect the data as contained in our records. **NOTE: Please supply the following information:**

Date of Membership: ____/____/____ Position/Title: _____

____/____/____ (____)____-____ _____
Date Telephone Number Signature of Local Board Secretary or Current Employer

SIGNEE TITLE: _____ E-MAIL ADDRESS: _____

TO BE COMPLETED BY PREVIOUS EMPLOYER:

I hereby certify that to the best of my knowledge and belief the statements made below are full, true and correct, and reflect the data as contained in our records. **NOTE: Please supply the following information:**

Date of Membership: ____/____/____ Position/Title: _____

Date of Termination: ____/____/____ Position/Title: _____

Annual Base Salary: \$_____

____/____/____ (____)____-____ _____
Date Telephone Number Signature of Local Board Secretary or Previous Employer

SIGNEE TITLE: _____ E-MAIL ADDRESS: _____

APPLICATION TO CALCULATE SEVERANCE REFUND REPAYMENT

PLEASE PRINT

1. MEMBER'S NAME: _____ SOC. SEC. NUMBER: _____-____-_____

ADDRESS:

(STREET) (APT. NO.) (CITY) (STATE) (ZIP)

2. CURRENT EMPLOYER: _____ CURRENT DATE OF MEMBERSHIP: _____

PREVIOUS EMPLOYER: _____

PREVIOUS SERVICE DATE: FROM _____ TERMINATION DATE _____

Both employers must be the same and the current date of membership must be within 2 years of the previous termination date (not the date of refund).

3. AMOUNT REFUNDED (If known): \$ _____ DATE: _____

4. A.R.S. SECTION 38-884, SUBSECTION I:

H. If a former member becomes re-employed with the same employer within two years after the former member's termination date, a member may have forfeited credited service attributable to service rendered during a prior period of service as an employee restored on satisfaction of each of the following conditions:

1. The member files with the plan a written application for reinstatement of forfeited credited service within ninety days after again becoming an employee.
2. The retirement fund is paid the total amount previously withdrawn pursuant to Subsection C, D or E of this section plus compound interest from the date of withdrawal to the dates of repayment. Interest shall be computed at the rate of nine per cent for each year compounded each year from the date of withdrawal to the date of repayment. Forfeited credited service shall not be restored until complete payment is received by the fund.
3. The required payment is completed within one year after returning to employee status.

I ACKNOWLEDGE READING the above and:

If I agree to reinstate my prior service credits which I previously refunded, I agree to redeposit the amount withdrawn from the system with interest at the rate of 9% compounded each year from the date of withdrawal to the date of repayment. This application does not require me to repay this amount, but I understand that I must pay this amount within one year from my current date of membership in order to reinstate my prior service credits.

Dated: _____ Member's Signature _____

(The applicant must file this form with the Plan within **90 days** after re-employment.)

EMPLOYER ACKNOWLEDGMENT

I hereby acknowledge that the information provided by the member above corresponds with the information in our personnel files, and that this application was submitted within 90 days of the member's reemployment with this agency.

/ / () -
Date Telephone Number Authorized Signature of Employer

Signer Title _____ Email Address _____

APPLICATION TO REDEEM PRIOR SERVICE WITHIN THE SAME RETIREMENT PLAN
(A.R.S. § 38-884)

A.R.S. § 38-884 Redemption of prior service

- J. A present active member of the plan who received a refund of accumulated contributions from the plan pursuant to subsection C, D, or E of this section and forfeited credited service pursuant to subsection H of this section may elect to redeem any part of that forfeited credited service by paying into the plan any amounts required pursuant to this subsection. A present active member who elects to redeem any part of forfeited credited service for which the member is deemed eligible by the board of trustees shall pay into the plan the amounts previously paid or transferred as a refund of the member's accumulated contributions plus an amount, computed by the plan's actuary that is necessary to equal the increase in the actuarial present value of projected benefits resulting from the redemption calculated using the actuarial methods and assumptions prescribed by the plan's actuary.

PLEASE PRINT

1. MEMBER'S NAME: _____ SOC. SEC. NUMBER: _____ - _____ - _____

DATE OF BIRTH: ____/____/____ TELEPHONE NUMBER: (____) ____ - _____

E-MAIL: _____

ADDRESS:

(Street) (Apt. No.) (City) (State) (Zip)

2. CURRENT EMPLOYER: _____

DATE OF HIRE: ____/____/____ CURRENT POSITION/TITLE: _____

CURRENT ANNUAL SALARY: \$ _____

3. PREVIOUS EMPLOYER: _____

DATE OF HIRE: ____/____/____ POSITION/TITLE: _____

DATE OF TERMINATION: ____/____/____ POSITION/TITLE: _____

4. FOR PARTIAL REDEMPTION ONLY, PLEASE INDICATE PERIOD REQUESTED:

Total period of time requested: _____ months and _____ days

I hereby certify that the information provided above is true, complete and correct to the best of my knowledge and belief. I further certify that the position(s) I held during the period requested for redemption were eligible for membership under the CORRECTIONS OFFICER RETIREMENT PLAN pursuant to A.R.S. Section 38-881.

Dated: ____/____/____

Member's Signature

CORRECTIONS OFFICER RETIREMENT PLAN

3010 E. Camelback Rd., Suite 200
(602)255-5575 FAX (602)296-2368 www.psprs.com

FORM C6

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APPLICATION FOR A SEPARATION REFUND OR DEFERRED ANNUITY

(A.R.S. Section 38-884, et. seq.)

NAME: _____ SOCIAL SECURITY NUMBER: _____

MAILING ADDRESS: _____
(Street) (Apt. No.) (City) (State) (Zip)

PHONE NUMBER: _____ BIRTH DATE: _____

MY CORP MEMBERSHIP EMPLOYMENT WITH: _____

BEGAN ON: _____ AND TERMINATED ON: _____

I certify that I have terminated my employment; I have not been accepted for employment with any other CORP employer in a designated eligible position; I have not previously received a refund of my accumulated contributions to the CORP; the dates of membership and termination in this application and the periods of leave of absence without pay are correct; I understand the terms and requirements for the Refund Option and the Deferred Annuity Option below; and I make my election as indicated below:

REFUND OPTION

By **INITIALING** _____ **this Refund Option**, I HEREBY make application for the refund of my member contributions to the CORRECTIONS OFFICER RETIREMENT PLAN (CORP) as well as any enhanced refund as provided by law. I understand that by withdrawing my accumulated contributions, I **TERMINATE MY MEMBERSHIP AND FORFEIT ALL RIGHTS TO BENEFITS** under the CORP and my rights to rehearing and appeal. I also understand that withdrawing my accumulated contributions results in forfeiture of my service credits in the CORP (A.R.S. § 38-884). Further, I understand that if I am again employed within two years by the same employer in a position covered under CORP, these service credits may be reinstated only if a written application for reinstatement is filed with the Board of Trustees within ninety (90) days after again becoming a covered employee and my refund contribution is re-deposited within one (1) year, along with applicable interest to date of re-deposit (A.R.S. § 38-884). I understand that if I do not withdraw my contributions and I obtain employment with an employer in a CORP covered position after my termination, my service credits will be transferred to my record with my new employer. Pursuant to A.R.S. Section 38-921, I may be entitled to transfer my service credits to a new retirement system upon subsequent employment in a position not covered by CORP and that by withdrawing my contributions, I am forfeiting all of these rights. If the refund includes taxable monies, I hereby acknowledge receiving and reading the special tax notice regarding these taxable monies. **If you elect the REFUND OPTION, a refund check will be mailed to the address shown above within 20 business days after your application is filed and your final wage deduction is transmitted to this office and your termination of covered employment has been verified by your employer.**

DEFERRED ANNUITY OPTION - Effective for a member who terminates on or after September 30, 2009 according to H.B. 2326

By **INITIALING** _____ **this Deferred Annuity Option A.R.S. 38-911**, I hereby elect to leave my accumulated contributions on deposit and receive a deferred annuity commencing on or after my 62nd birthday. I understand that I may elect this deferred annuity only if I have at least ten years of credited service in the CORP. I also understand that if I die and I have accumulated contributions remaining in the CORP, those accumulated contributions will be paid to my designated refund beneficiary, if living, or to my designated contingent refund beneficiary, if living, or to my nearest living kin as selected by my local CORP board. A Deferred Annuity shall be a lifetime monthly pension actuarially equivalent to the member's accumulated contributions plus an amount paid by the employer, and shall commence on application, on or after the 62nd birthday. The Annuity is not a retirement benefit and annuitants are not entitled to receive any amount prescribed by section 38-887, 38-888, 38-904, 38-905 or 38-906. All changes of address must be reported, in writing, to the local CORP board and the Board of Trustees.

TAXABLE MONIES (All monies contributed after July 1, 2000 are taxable monies)

You must complete the information below before a refund check is issued.

By **INITIALING** _____, I understand and acknowledge the following:

1. I am aware that I have at least 30 days to decide whether I want to elect a direct rollover or to elect a cash distribution of my taxable monies and I am electing to waive this 30 day waiting period.
2. I have completed the Lump Sum Distribution Election Form that prescribes certain tax consequences regarding the above taxable monies.
3. I have received and read the special tax notice regarding these taxable monies and understand the tax consequences explained in the notice and election form.

If this application form is not witnessed or initialed, or if the Lump Sum Distribution Election form is not completed, it will be returned which will cause a delay in the processing of any enhanced portion of your refund.

If you divorced during your employment, provide our office with a copy of your Divorce Decree or Domestic Relations Order. Note: A.R.S. §§ 38-860, 38-910, 38-822 states that if you have been involved in a divorce, the System/Plan is not liable for any benefits you receive. You are considered trustee to the funds and will be the sole party against with whom an action may be brought to recover the payment.

I declare under penalty of perjury that the above information is true, correct and complete to the best of my knowledge and belief.

DATE

EMPLOYEE'S SIGNATURE

WITNESS

NAME: _____

SSN: _____

EMPLOYER'S CERTIFICATION OF TERMINATION

INSTRUCTIONS: The Employer must complete this Certification of Termination and send it back to the Board of Trustees with a copy to the Local Board.

NAME OF EMPLOYER: _____

Applicant's final wage period was from _____ through _____

Last date of employment: _____

Employee contributions for final wage period by applicant total \$ _____

(The Board of Trustees will deduct prior payments, if any, made by the CORP to or on behalf of the applicant to arrive at refundable accumulated contributions. A.R.S. Sections 38-884 and 38-899)

The undersigned representative of the employer hereby certifies that the applicant named above has actually terminated his employment and agrees that any excess refund paid to the applicant due to an overstatement of the total aggregate employee contributions shall be the liability of the employer. I also acknowledge that the membership date and termination date provided by the employee above corresponds with the information in our personnel files.

EMPLOYER'S REPRESENTATIVE:

SIGNATURE	TITLE	TELEPHONE NUMBER	DATE
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If you have five or more years of credited service with the plan you are entitled to receive additional monies according to the following schedule:

- 5 to 5.9—25% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-891, subsection B.
- 6 to 6.9—40% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-891, subsection B.
- 7 to 7.9—55% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-891, subsection B.
- 8 to 8.9—70% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-891, subsection B.
- 9 to 9.9—85% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-891, subsection B.
- 10 or more—100% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-891, subsection B, plus interest at 3% after 30 days if left on deposit.

All of the additional monies prescribed above are taxable monies. NOTE: Periods of time during which you were on a leave of absence without pay **do not** count as credited service.

LEAVES OF ABSENCE WITHOUT PAY (Complete only if you have five or more years of credited service)

During my periods of covered service, I have been on leave of absence without pay as indicated below: **(Initial and complete)**

- _____ (a) NONE
- _____ (b) From _____ / _____ / _____ Through _____ / _____ / _____ Employer _____
- From _____ / _____ / _____ Through _____ / _____ / _____ Employer _____
- From _____ / _____ / _____ Through _____ / _____ / _____ Employer _____

EMPLOYER'S CERTIFICATION OF INFORMATION
(Complete only if the employee has five or more years of credited service)

The undersigned representative of the employer hereby certifies that the periods of leave of absence without pay provided by the applicant named on the reverse hereof corresponds with the information in our personnel files.

EMPLOYER'S REPRESENTATIVE:

SIGNATURE	TITLE	TELEPHONE NUMBER	DATE
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**PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
CORRECTIONS OFFICER RETIREMENT PLAN
ELECTED OFFICIALS' RETIREMENT PLAN**
3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016
(602)255-5575 FAX (602)296-2368 www.psprs.com

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APPLICATION TO PURCHASE ACTIVE MILITARY SERVICE

(A.R.S. Sections 38-858, 38-907 or 38-820)

A member of the system/plan who has at least **TEN** years of service with the system may receive credited service for periods of active military service performed before employment with the member's current employer

PLEASE PRINT

MEMBER'S NAME: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____
(Street) (City) (State) (Zip)

TELEPHONE: () _____ E-MAIL: _____ BIRTHDATE: _____

CURRENT EMPLOYER: _____

MEMBERSHIP DATE: ____/____/____

CURRENT POSITION/CLASSIFICATION: _____

MONTHS OF ACTIVE MILITARY SERVICE WHICH I REQUEST TO PURCHASE: _____ (Maximum: 60 months)

BRANCH OF MILITARY SERVICE _____

FROM ____/____/____ THROUGH ____/____/____

- COPY OF MILITARY SERVICE RECORD (DD-214) ATTACHED (Must Indicate HONORABLE)
- COPY OF MILITARY DISCHARGE CERTIFICATE (DD-256A) ATTACHED. IF NOT ATTACHED, PLEASE EXPLAIN: _____

Please **INITIAL** each of the following to indicate your agreement and/or understanding, otherwise this form will not be processed.

- ____ I was honorably separated
- ____ This time is Active Military time (reserve time is ineligible)
- ____ I have not purchased this military time towards any other pension program

The information in this application is true and correct to the best of my knowledge and pursuant to A.R.S. Section 38-858, 38-907 or 38-820 I request that the Board of Trustees calculate the amounts required to be paid in order to receive credited service for previous active military service.

I understand that any person who knowingly makes any false statement, or who falsifies or permits to be falsified any record of the retirement plan with an intent to defraud the plan or attempts to defraud the system or plan is guilty of a Class 6 felony Arizona Revised Statutes Section 38-849 and may result in total loss of benefits under the PSPRS retirement system.

DATE: ____/____/____ _____
Signature of Member

CORRECTIONS OFFICER RETIREMENT PLAN

3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016
(602)255-5575 FAX (602)296-2368 www.psprs.com

FORM C19

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APPLICATION FOR OPTION TO CONTRIBUTE DURING INDUSTRIAL LEAVE

A.R.S. Section 38-891, subsection D provides in part:

D. During a period when an employee is on industrial leave and the employee elects to continue contributions during the period of industrial leave, the employer and employee shall make contributions based on the compensation the employee would have received in the employee's job classification if the employee was in normal employment status.

NAME: _____ SOCIAL SECURITY NUMBER: _____ - _____ - _____

DURING MY PERIOD OF EMPLOYMENT WITH _____,
I WILL RECEIVE COMPENSATION BENEFITS UNDER THE ARIZONA STATE WORKERS' COMPENSATION LAWS.
PURSUANT TO A.R.S. SECTION 38-891, SUBSECTION D,

PLEASE INITIAL ONE:

Beginning ____/____/____, I ELECT TO CONTINUE

I ELECT TO STOP

MAKING CONTRIBUTIONS TO THE CORRECTIONS OFFICER RETIREMENT PLAN DURING MY PERIOD OF INDUSTRIAL LEAVE.

IF I ELECT TO CONTINUE MAKING CONTRIBUTIONS TO THE CORRECTIONS OFFICER RETIREMENT PLAN DURING THE PERIOD I AM ON INDUSTRIAL LEAVE, MY EMPLOYEE AND EMPLOYER CONTRIBUTIONS WILL BE BASED ON THE COMPENSATION I WOULD HAVE RECEIVED IN MY JOB CLASSIFICATION AS IF I WAS IN NORMAL EMPLOYMENT STATUS.

IF I ELECT TO STOP MAKING CONTRIBUTIONS TO THE CORRECTIONS OFFICER RETIREMENT PLAN DURING THE PERIOD I AM ON INDUSTRIAL LEAVE, IN DETERMINING MY NORMAL RETIREMENT DATE, THIS PERIOD WILL BE CONSIDERED AS "SERVICE" BUT NOT "CREDITED SERVICE".

MEMBER:

_____/_____/____ (____)____-____ _____
Date Telephone Number Member's Signature

E-MAIL ADDRESS: _____

EMPLOYER:

_____/_____/____ (____)____-____ _____
Date Telephone Number Authorized Signature of Employer

E-MAIL ADDRESS: _____ TITLE: _____

REQUEST TO REMAIN IN THE CORRECTIONS OFFICER RETIREMENT PLAN
(A.R.S. Section 38-891, subsection E)
(Applies to Department of Corrections or the Department of Juvenile Corrections Only)

When Completed return to: Department of _____ CORP Local Board

Address: _____

NAME: _____ SOCIAL SECURITY NUMBER: _____ - _____ - _____

ADDRESS: _____ WORK LOCATION: _____

PHONE NUMBER: (____) _____ - _____ DATE OF BIRTH: ____/____/____

I am transferring or being reassigned from a Corrections Officer Retirement Plan designated position to a non-designated position within the department. The transfer or reassignment is for the purpose of temporarily filling a non-designated department position. I currently have five or more years of credited service with the Corrections Officer Retirement Plan. Pursuant to A.R.S. Section 38-891, subsection E, I request that the local board temporarily specify my new position as a designated position in the department.

FORMER DESIGNATED POSITION: _____

CORP MEMBERSHIP DATE - FROM: ____/____/____ TO: ____/____/____

PRIOR SERVICE WITH THE CORP: _____

TOTAL YEARS OF CREDITED SERVICE: _____

NEW NON-DESIGNATED POSITION: _____

START DATE: ____/____/____

NOTE: This request can be made before the transfer but must be made within 90 days of the starting date to the new non-designated position.

If employee contributions have been made to the Arizona State Retirement System after the above start date, these monies will be reversed from the ASRS to the CORP. However, I agree to make arrangements with my department for a one-time payment to pay the additional employee contributions representing the difference between the CORP employee contributions and the ASRS employee contributions.

TODAY'S DATE: ____/____/____

SIGNATURE OF MEMBER: _____

WITNESS: _____

(Over)

REQUEST TO REMAIN IN THE CORRECTIONS OFFICER RETIREMENT PLAN (Continued)
(A.R.S. Section 38-891, subsection E)

A.R.S. Section 38-891, subsection E provides:

E. The local board of the state department of corrections or the local board of the department of juvenile corrections may specify a position within that department as a designated position if the position is filled by an employee who has at least five years of credited service under the plan, who is transferred to temporarily fill the position and who makes a written request to the local board to specify the position as a designated position within ninety days of being transferred. On the employee leaving the position, the position is no longer a designated position.

TO BE COMPLETED BY LOCAL BOARD:

The Corrections Officer Retirement Plan Local Board has reviewed this request and has verified that the information in this request is accurate and conforms to our records and the records of the personnel office. Based on the information contained in this request, on and after the start date as prescribed in this request, we specify the non-designated position that is being filled temporarily by _____ as a CORP designated position.

DATE APPROVED: ____/____/____ TELEPHONE NUMBER: (____) ____-____

SIGNATURE OF SECRETARY OR LOCAL BOARD CHAIRMAN: _____

- COPY SENT TO BOARD OF TRUSTEES, CORRECTIONS OFFICER RETIREMENT PLAN
- COPY SENT TO DEPARTMENT PAYROLL OFFICE
- COPY SENT TO DEPARTMENT PERSONNEL OFFICE
- COPY SENT TO APPLICANT

TO PAYROLL OFFICE: Please ensure that the correct employee and employer contributions are made on a pre-tax basis to the Corrections Officer Retirement Plan on and after the start date as prescribed in this request. If contributions have been made to the Arizona State Retirement System, please reverse any pre-tax employee and employer contributions made to the Arizona State Retirement System and forward the correct employee and employer contributions on a pre-tax basis for the above employee for the prescribed periods of time to the Corrections Officer Retirement Plan.

REQUEST TO REMAIN IN THE ARIZONA STATE RETIREMENT SYSTEM
(A.R.S. Section 38-891, subsection F)

(Applies to Department of Corrections or the Department of Juvenile Corrections Only)

When completed return to: Department of _____ CORP Local Board

Address: _____

NAME: _____ SOCIAL SECURITY NUMBER: _____ - _____ - _____

ADDRESS: _____ WORK LOCATION: _____

WORK NUMBER: (____) _____ - _____ DATE OF BIRTH: ____/____/____

I am an employee who currently has five or more years of credited service with Arizona State Retirement System and am transferring, being reassigned or employed in a designated CORP position within the department. Pursuant to A.R.S. Section 38-891, subsection F, I request that the local board specify my new position as a non-designated position in the department and that I be allowed to remain in the ASRS. Upon my leaving this position, the position will revert back to a designated CORP position.

FORMER ASRS POSITION: _____

ASRS MEMBERSHIP DATE - FROM: ____/____/____ TO: ____/____/____

TOTAL YEARS OF CREDITED SERVICE WITH THE ASRS: _____

NEW CORP DESIGNATED POSITION: _____

START DATE: ____/____/____

NOTE: This request can be made before the transfer but must be made within 90 days of the starting date to the new CORP-designated position.

If employee contributions have been made to the Corrections Officer Retirement Plan after the above start date, these monies will be reversed from the Corrections Officer Retirement Plan to the Arizona State Retirement System and I will be receiving from the department a return of excess contributions that were made to the CORP, representing the difference between the CORP employee contributions and the ASRS employee contributions.

TODAY'S DATE: ____/____/____

SIGNATURE OF MEMBER: _____

WITNESS: _____

(Over)

REQUEST TO REMAIN IN THE ARIZONA STATE RETIREMENT SYSTEM
(A.R.S. Section 38-891, subsection F)

A.R.S. Section 38-891, subsection F provides:

F. The local board of the State Department of Corrections or the local board of the Department of Juvenile Corrections may specify a designated position within the department as a non-designated position if the position is filled by an employee who has at least five years of credited service under the Arizona State Retirement System and who makes a written request to the local board to specify the position as a non-designated position within ninety days of accepting the position. On the employee leaving the position, the position reverts to a designated position.

TO BE COMPLETED BY LOCAL BOARD:

The Corrections Officer Retirement Plan Local Board has reviewed this request and has verified that the information in this request is accurate and conforms to our records and the records of the personnel office. Based on the information contained in this request, on and after the Start Date as prescribed in this request, we specify the designated CORP position as a non-designated position until the employee vacates this position.

DATE APPROVED: ____/____/____

TELEPHONE NUMBER: (____) ____-____

SIGNATURE OF SECRETARY OR LOCAL BOARD CHAIRMAN: _____

- COPY SENT TO THE ARIZONA STATE RETIREMENT SYSTEM
- COPY SENT TO DEPARTMENT PAYROLL OFFICE
- COPY SENT TO DEPARTMENT PERSONNEL OFFICE
- COPY SENT TO APPLICANT

TO PAYROLL OFFICE: Please ensure that the correct employee and employer contributions are made on a pretax basis to the Arizona State Retirement System on and after the Start Date as prescribed in this request. If contributions have been made to the Corrections Officer Retirement Plan, please reverse the pre-tax employee and employer contributions made to the Corrections Officer Retirement Plan and forward the correct employee and employer contributions on a pre-tax basis for the above employee for the prescribed periods of time to the Arizona State Retirement System.

OUT OF STATE SERVICE AFFIDAVIT (Employee)

DO NOT ALTER THIS FORM OR USE WHITE OUT

Pursuant to A. R. S. Section 38-909, Each present active member of the plan who has at least **TEN** years of credited service with the plan may elect to redeem up to **SIXTY** months of any part of the following prior service or employment by paying into the plan any amounts required under subsection B if the prior service is not on account with any other retirement system.

I hereby make application for a calculation to redeem service credits refunded from an agency of the United States government, a state of the United States or a political subdivision of a state of the United States as a full-time paid corrections officer or full-time paid certified peace officer to my current retirement system in this state.

Member Name _____		Social Security Number _____ - _____ - _____	Date of Birth _____ / _____ / _____ () -
Address (Street) _____	(City) _____	(State) _____	(Zip) _____
Former Employer or Retirement System Name _____		Position Held _____	Contact Person _____ () -
Address (Street) _____	(City) _____	(State) _____	(Zip) _____
Prior Service Dates: From _____ / _____ / _____		to _____ / _____ / _____	

To redeem refunded credited service, indicate number of months you wish to have calculated: _____

Current Employer _____	Current Retirement System or Plan _____
Service Date _____ / _____ / _____	Current Position/Classification _____

YOU MUST READ, COMPLETE AND INITIAL THE FOLLOWING if you participated in a retirement plan during the time periods listed above.
_____ I am no longer eligible for a benefit from the _____ Retirement Plan because I took a refund from the plan on or about _____ (approximate date) or there were no benefits available to me when I terminated my membership in the plan.
_____ I am currently eligible for a retirement benefit from the _____ Retirement Plan, but will forfeit my benefits from that plan before I make arrangements to purchase the above service time

Please INITIAL each of the following to indicate your agreement and/or understanding, otherwise this form will not be processed:
_____ I understand that this transaction is subject to audit. If any misrepresentations are discovered as a result of this audit, my total credited service with the CORP will be adjusted as necessary. Any overpayments will be refunded. I further understand that if an error or misrepresentation is discovered after I retire, any adjustments to my credited service will affect my retirement benefit. In addition, if payment for the purchase was made with pre-tax dollars and is returned to me, there will be tax consequences as a result of this refund.
_____ I understand that an audit may determine that I am eligible for a benefit from the retirement plan listed above after I have already been allowed to purchase service from the CORP because I indicated that I was NOT eligible for a benefit. If this occurs, I will immediately take steps necessary to forfeit my benefit in the above retirement plan. I understand that if this forfeiture is not completed in a reasonable amount of time, any CORP service, which I have purchased, based on the employment listed above will be revoked and my money refunded, without interest.
_____ I certify under penalty of perjury that I was employed as a full-time paid corrections officer or certified peace officer by the above employer during the dates listed.

Furthermore, I hereby certify that the above information is true and correct to the best of my knowledge and request that the Board of Trustees calculate the amounts required to be paid in order to accomplish the requested redemption pursuant to A.R.S. Section 38-909.

Signature of Member _____		Date _____ / _____ / _____
State of _____	County of _____	
The foregoing was acknowledged before me on this _____		
Day of _____, 20 _____		
By _____ (Member's Name)		Notary Seal
Notary Public Signature _____	My Commission Expires _____ / _____ / _____	

OUT OF STATE SERVICE AFFIDAVIT

(Employer/Retirement Plan Administrator)

The person named below is requesting that you verify the following information about his/her employment with your system in order to purchase time in the Arizona Corrections Officer Retirement Plan. Please verify the following information and answer the questions below:

A

_____		_____	_____
Member Name		Social Security Number	Date of Birth
_____		_____	_____
Former Employer or Retirement System Name		Position Held	Contact Person
_____		_____	() - _____
Member Address	(Street)	(City)	(State) (Zip)
_____		_____	
Current Employer		Current Retirement System or Plan	
_____		/ /	
Member Signature		Date	

B Previous Employer: Please answer the following questions:

1. Is/Was the person named above employed with your system as a full-time paid corrections officer or full-time paid certified peace officer? Yes No
2. If yes, please provide the full-time paid certified service dates: _____ / _____ / _____
Service Date From Service Date Through
3. Is/Was the person named above an employee covered by your system's retirement plan? Yes No
(If, the answer to questions 1 and 3 are both, yes, please sign below and forward this form to your retirement system's administrator for completion. If you answered, no, to either question, please sign this form and send it directly to our office at the address listed above.)

I hereby certify that the above information is true and correct to the best of my knowledge.

_____	_____
Authorized Signature of Previous Employer	Date
_____	_____
Title	Phone
_____	_____
Agency Name	

C Retirement Plan Administrator: Arizona law does not allow credit in its retirement system for service time in another pension plan if such service entitles the individual to a current or future benefit in that plan. Please answer the following questions:

1. Does this member still have member contributions in your retirement plan? Yes No
2. Has this member forfeited any and all rights to a benefit(s) under your retirement system? Yes No

I hereby certify that the above information is true and correct to the best of my knowledge.

_____	_____
Authorized Signature of Retirement Plan Administrator	Date
_____	_____
Title	Phone
_____	_____
Retirement System Name	

When Completed
Return to:

CORRECTIONS OFFICER RETIREMENT PLAN
3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016
(602)255-5575 FAX (602)296-2368 www.psprs.com

FORM CSR
Page 1 of 1
08/11

**APPLICATION TO REDEEM TIME WITH AN ARIZONA CORRECTIONS
OFFICER EMPLOYER PRIOR TO JOINDER DATE**
(A.R.S. Section 38-909 Subsection A)

38-909 Redemption of prior service

A. Each present active member of the plan who has at least **TEN** years of credited service with the plan who had previous service in this state as an employee with an employer now covered by the plan or who had previous service with an agency of the United States Government, a state of the United States or a political subdivision of a state of the United States as a full-time paid corrections officer or full-time paid certified peace officer may elect to redeem up to **SIXTY** months of any part of the prior service by paying into the plan any amounts required under subsection B if the prior service is not on account with any other retirement system.

PLEASE PRINT

MEMBER'S NAME: _____

SOCIAL SECURITY NUMBER: _____ BIRTH DATE: _____ / _____ / _____

ADDRESS: _____

PHONE NUMBER: () _____ E-MAIL ADDRESS: _____

CURRENT EMPLOYER:

Date of Membership: _____ / _____ / _____ Position/Title: _____

PREVIOUS EMPLOYER:

Service Date From: _____ / _____ / _____ Position/Title: _____

Service Date Through: _____ / _____ / _____

Please indicate the number of months you wish to have calculated: _____

I hereby certify that the above information is true and correct to the best of my knowledge and request that the Fund Manager calculate the amounts required to be paid in order to accomplish the requested redemption pursuant to A.R.S. 38-909.

Dated: _____ / _____ / _____

Signature of Member

TO BE COMPLETED BY PREVIOUS EMPLOYER:

I hereby certify that to the best of my knowledge and belief the information provided below is true and correct, and reflect the data as contained in our records.

Please provide the full-time paid corrections officer service dates: _____ / _____ / _____ Service Date From _____ / _____ / _____ Service Date Through

Position/Title: _____

Has this member forfeited any and all rights to a benefit(s) under the former retirement system? Yes No N/A

_____/_____/_____ (_____)_____-_____
Date Telephone Number Signature of Previous Employer

SIGNEE TITLE: _____ E-MAIL ADDRESS: _____

**PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
CORRECTIONS OFFICER RETIREMENT PLAN
ELECTED OFFICIALS' RETIREMENT PLAN**
3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016
(602)255-5575 FAX (602)296-2368 www.psprs.com

APPLICATION TO TRANSFER OR REDEEM SERVICE CREDITS BETWEEN ARIZONA RETIREMENT PLANS
(A.R.S. Sections 38-921 and 38-922)

To: Board of Trustees

Pursuant to A.R.S. Sections 38-921 and 38-922, I hereby make application for a calculation to transfer retirement service credits on account or refunded from another retirement system or plan in this state to my current retirement system or plan in this state.

I. Member's Name: _____ Telephone Number: () - _____

Address: _____
(Street) (Apt No.) (City) (State) (Zip)

Social Security Number: - - _____ Date of Birth: / / _____

II. Former Retirement System or Plan: _____

Former Employer: _____
(EMPLOYER WHILE CONTRIBUTING TO FORMER PLAN)

Former Position/Classification: _____

Prior Service Dates: From ____/____/____ to ____/____/____

If redeeming refunded credited service, indicate number of months you wish to have calculated: _____

Did you refund (withdraw) your member contributions from prior retirement system or plan?

YES

NO

This form will be sent to your prior retirement system or plan to request an actuarial present value or to verify your previous credited service. We cannot send you an offer to purchase or transfer credited service until we receive this information.

III. Current Retirement System or Plan: _____

Current Employer: _____

Service Date: ____/____/____

Current Position/Classification: _____

PLEASE INITIAL:

_____ **THIS FORM IS AN APPLICATION FOR A QUOTE ONLY AND DOES NOT AUTOMATICALLY TRANSFER MY TIME.**

I hereby certify that the above information is true and correct to the best of my knowledge and request that the Board of Trustees calculate the amounts required to be transferred or paid in order to accomplish the requested transfer pursuant to A.R.S. Sections 38-921 and 38-922.

Dated: ____/____/____ _____

Signature of Member

TITLE 38, CHAPTER 5, ARTICLE 7
TRANSFER TO ANOTHER RETIREMENT SYSTEM OR PLAN

38-921. Transfer of retirement service credits from one retirement system or plan to another retirement system or plan in this state

- A. An active or inactive member of a state retirement system or plan, including the retirement system provided for in article 2 of this chapter, the Elected Officials' Retirement Plan provided for in article 3 of this chapter, the Public Safety Personnel Retirement System provided for in article 4 of this chapter or the Corrections Officer Retirement Plan provided for in article 6 of this chapter may transfer service credits from one system or plan to the member's current or former system or plan pursuant to section 38-922 if all of the following conditions are met:
1. The board or board of trustees governing the retirement system or plan from which the service credits are being transferred mutually agrees with the board or board of trustees governing the retirement system or plan to which the service credits are being transferred regarding the terms of the transfer.
 2. The transfer does not cause either the retirement system or plan to which the transfer is made or the retirement system or plan from which the transfer is made to incur any unfunded accrued liabilities as a result of the transfer.
 3. The member initiates the transfer by making written application to the governing board or board of trustees of the retirement system or plan to which the member is contributing.
- B. For the purposes of this section:
1. "Active member" means a member who satisfies the eligibility criteria of the state retirement system or plan and who is currently making member contributions to or receiving credited service from the state retirement system or plan.
 2. "Inactive member" means a member of the state retirement system or plan who previously made contributions to the state retirement system or plan and who satisfies each of the following:
 - (a) Has not retired.
 - (b) Is not eligible for active membership in the state retirement system or plan.
 - (c) Is not currently making contributions to the state retirement system or plan.
 - (d) Has not withdrawn contributions from the state retirement system or plan.

Added by Laws 1989, Ch.310, § 16; Laws 1995, Ch. 32, § 19; Amended by Laws 2001, Ch. 123 §1.

38-922. Transfer or redemption of service credits

- A. Service credits qualified in accordance with section 38-730 or 38-921 may be transferred or redeemed in accordance with this section.
- B. In the case of a member whose contributions remain on deposit with the prior retirement system or plan, the following shall be calculated:
1. The prior system or plan shall calculate the amount equal to the actuarial present value of a member's projected benefits to the extent funded on a market value basis as of the most recent actuarial valuation under the prior system or plan as calculated by that system's or plan's actuary using the same actuarial method and assumptions used in calculating that system's or plan's funding requirements based on the transferring member's service credits at the time of transfer. If a system's or plan's market value is greater than one hundred per cent, the system or plan shall use a one hundred per cent market value.
 2. The system or plan to which the member is transferring shall calculate the increase in the actuarial present value of the projected benefits provided as a result of the transfer of the member's service credits. This calculation shall be performed by that system's or plan's actuary using the same actuarial method and assumptions used in calculating that system's or plan's funding requirements based on the transferring member's service credits at the time of transfer.
- C. In the event a member decides to transfer:
1. If the amount calculated in subsection B, paragraph 2 is greater than the amount calculated in subsection B, paragraph 1:
 - (a) The prior system or plan shall transfer to the present system or plan the greater of the amount calculated in subsection B, paragraph 1 or the member's accumulated contribution account balance.
 - (b) If the amount transferred is less than the amount calculated under subsection B, paragraph 2, the transferring member shall elect either to pay the difference or to accept a reduced transfer of service credits. If the member elects to pay the difference, the amount paid shall be added to the member's accumulated contribution account balance. If the member elects to accept a reduced transfer of service credits, the amount of service credits transferred shall be equal to the amount of service credits used in making the calculation under subsection B, paragraph 1 multiplied by the ratio of the amount calculated under subsection B, paragraph 1 to the amount calculated under subsection B, paragraph 2.
 2. If the amount calculated in subsection B, paragraph 2 is less than or equal to the amount calculated in subsection B, paragraph 1, the prior system or plan shall transfer to the present system or plan the greater of the amount calculated in subsection B, paragraph 2 or the member's accumulated contribution account balance.
- D. In the case of an applicant who has withdrawn the applicant's member contributions from another prior system or plan of this state, the applicant shall pay into the new system or plan to which the applicant is transferring an amount equal to the increase in the actuarial present value of the projected benefits provided by the service credits being redeemed and this amount shall be included in the member's current accumulated contribution account balance. This calculation shall be performed by the actuary of the system or plan to which the service credits are being transferred using the same actuarial method and assumptions used in calculating that system's or plan's funding requirements.
- E. Service credits shall not be applied to the applicant's account until such time as complete payment is made to the retirement system or plan to which the applicant is transferring. On completion of the transfer provided for in this article, the member's rights in the retirement system or plan from which the member is transferring are extinguished.
- F. A member electing to transfer to or redeem service with the Public Safety Personnel Retirement System, the Elected Officials' Retirement Plan or the Corrections Officer Retirement Plan pursuant to this section may pay for the service being transferred or redeemed in the form of a lump sum payment to the system or plan, a trustee-to-trustee transfer or a direct rollover of an eligible distribution from a plan described in section 402(c)(8)(B) (iii), (iv), (v) or (vi) of the internal revenue code or a rollover of an eligible distribution from an individual retirement account or annuity described in section 408(a) or (b) of the internal revenue code.

Added as § 38-952 by Laws 1989, Ch. 310, § 16. Renumbered as § 38-922; Amended by Laws 1991, Ch. 270, § 10; Laws 2009, Ch. 35, § 31, effective September 30, 2009. Amended by Laws 2011, Ch. 277.

**PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
CORRECTIONS OFFICER RETIREMENT PLAN
ELECTED OFFICIALS' RETIREMENT PLAN**

3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016
(602)255-5575 FAX (602)296-2368 www.psprs.com

**APPLICATION TO TRANSFER SERVICE CREDITS BETWEEN MUNICIPAL RETIREMENT SYSTEMS
AND SPECIAL RETIREMENT PLANS**

(A.R.S. Sections 38-923 and 38-924)

To: Board of Trustees

Pursuant to A.R.S. Sections 38-923 and 38-924, I hereby make application for a calculation to transfer retirement service credits on account from a municipal retirement system or plan to my current retirement system or plan in this state.

I. Member's Name: _____ Telephone Number: (____) ____ - _____

Address: _____
(Street) (Apt No.) (City) (State) (Zip)

Social Security Number: _____ - _____ Date of Birth: ____ / ____ / ____

II. Former Retirement System or Plan: _____

Former Employer: _____

Former Position/Classification: _____

Prior Service Dates: From ____ / ____ / ____ to ____ / ____ / ____ (_____ years)

This form will be sent to your prior retirement system or plan to request an actuarial present value or to verify your previous credited service. We cannot send you an offer to transfer credited service until we receive this information.

III. Current Retirement System or Plan: _____

Current Employer: _____

Service Date: ____ / ____ / ____

Current Position/Classification: _____

PLEASE INITIAL:

_____ **THIS FORM IS AN APPLICATION FOR A QUOTE ONLY AND DOES NOT AUTOMATICALLY TRANSFER MY TIME.**

I hereby certify that the above information is true and correct to the best of my knowledge and request that the Board of Trustees calculate the amounts required to be transferred or paid in order to accomplish the requested transfer pursuant to A.R.S. Sections 38-923 and 38-924.

Dated: ____ / ____ / ____

Signature of Member

TITLE 38, CHAPTER 5, ARTICLE 7
TRANSFER OF SERVICE CREDITS BETWEEN MUNICIPAL RETIREMENT SYSTEMS AND SPECIAL RETIREMENT PLANS

38-923. Transfer of service credits between municipal retirement systems and special retirement plans; definitions

- A. An active or inactive member of a retirement system or plan of a municipality of this state or the Public Safety Personnel Retirement System who becomes a member of one or the other of these retirement systems or plans may transfer service credits from the member's prior retirement system or plan to the member's current retirement system or plan pursuant to section 38-924 if all of the following conditions are met:
1. The board or board governing the retirement system or plan from which the service credits are being transferred mutually agrees with the board or board governing the retirement system or plan to which the service credits are being transferred regarding the terms of the transfer.
 2. The transfer does not cause either the retirement system or plan to which the transfer is made or the retirement system or plan from which the transfer is made to incur any unfunded accrued liabilities as a result of the transfer.
 3. The member initiates the transfer by making written application to the governing board or board of the retirement system or plan to which the member is contributing.
- B. An active or inactive member of a retirement system or plan of a municipality of this state or the Corrections Officer Retirement Plan who becomes a member of one or the other of these retirement systems or plans may transfer service credits from the member's prior retirement system or plan to the member's current retirement system or plan pursuant to Section 38-924 if all of the following conditions are met:
1. The board or board governing the retirement system or plan from which the service credits are being transferred mutually agrees with the board or board governing the retirement system or plan to which the service credits are being transferred regarding the terms of the transfer.
 2. The transfer does not cause either the retirement system or plan to which the transfer is made or the retirement system or plan from which the transfer is made to incur any unfunded accrued liabilities as a result of the transfer.
 3. The member initiates the transfer by making written application to the governing board or board of the retirement system or plan to which the member is contributing.
- C. For the purposes of this section:
1. "Active member" means a member who satisfies the eligibility criteria of the retirement system or plan and who is currently making member contributions to or receiving credited service from the retirement system or plan.
 2. "Inactive member" means a member of the retirement system or plan who previously made contributions to the retirement system or plan and who satisfies each of the following:
 - (a) has not retired.
 - (b) is not eligible for active membership in the retirement system or plan.
 - (c) is not currently making contributions to the retirement system or plan.
 - (d) has not withdrawn contributions from the retirement system or plan.
 3. "Municipality" means a city in this state with a population of more than five hundred thousand persons.

Added Laws 2006, Ch. 264, § 22.

38-924. Transfer of service credits

- A. Service credits qualified pursuant to section 38-923 may be transferred pursuant to this section.
- B. In the case of a member whose contributions remain on deposit with the prior retirement system or plan, the following shall occur:
1. The prior system or plan shall determine the amount of the member's accumulated contribution account balance under the prior system or plan plus accumulated interest as determined by the governing body of the system or plan.
 2. The system or plan to which the member is transferring shall calculate any increase in the actuarial present value of the projected benefits provided as a result of the transfer of the member's service credits. The actuary of the system or plan to which the service credits are being transferred shall perform this calculation using the actuarial method and assumptions recommended by the actuary and adopted by the governing body of the retirement system or plan.
- C. If a member decides to transfer:
1. The prior system or plan shall transfer to the present system or plan the amount determined pursuant to subsection B, paragraph 1 of this section. if the amount calculated in subsection B, paragraph 2 of this section is greater than the amount determined in subsection B, paragraph 1 of this section, the transferring member shall either elect to pay the difference in order to receive all service credits earned under the prior system or plan or to accept a reduced transfer of service credits. if the member elects to pay the difference, the amount paid shall be added to the member's accumulated contribution account balance. if the member elects to accept a reduced transfer of service credits, the amount of service credits transferred shall be equal to the amount of service credits earned under the prior system or plan corresponding to the amount determined under subsection B, paragraph 1 of this section multiplied by the ratio of the amount calculated under subsection B, paragraph 1 of this section to the amount calculated under subsection B, paragraph 2 of this section.
 2. If the amount calculated in subsection B, paragraph 2 of this section is less than or equal to the amount determined in subsection B, paragraph 1 of this section, the current system or plan shall credit the member with service credits under the current system or plan equal to the service credit earned under the prior system or plan corresponding to the amount determined under subsection B, paragraph 1 of this section.
- D. The retirement system or plan shall not apply service credits to the applicant's account until such time as complete payment is made to the retirement system or plan to which the applicant is transferring. On completion of the transfer provided for in this article, the member's rights in the retirement system or plan from which the member is transferring are extinguished.

Added by Laws 2006, Ch. 264, § 22.

**PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
CORRECTIONS OFFICER RETIREMENT PLAN
ELECTED OFFICIALS' RETIREMENT PLAN**

FORM U3 - Refunds

08/11

Page 1 of 2

P (602) 255-5575

3010 East Camelback Road, Suite 200, Phoenix, Arizona 85016-4416

F (602) 296-2368

www.psprs.com

LUMP SUM DISTRIBUTION ELECTION FORM FOR REFUNDS

Name: _____

SSN: _____

Date of Termination: _____

All or a portion of your refund/distribution may represent TAXABLE monies. If so, you must complete the following with regard to the TAXABLE portion of the distribution received. The non-taxable portion will be paid directly to you. Please review the special tax notice (Available On-Line) and consult with your tax advisor.

Please select Option A, B or C below:

A. FULL REFUND/DISTRIBUTION TO MEMBER

The PSPRS, CORP or EORP is directed to make full payment to me, the member, less any applicable withholding described in the Special Tax Notice received with this election form (20% Federal Withholding).

Signature of Member

Date

B. DIRECT TRANSFER (Representative of Financial Institution must complete Page 2)

The PSPRS, CORP or EORP is directed to mail the taxable portion only of my distribution to:

(Name of Financial Institution)

for deposit in accordance with the rollover provisions. The non-taxable portion will be paid directly to me.

Signature of Member

Date

C. PARTIAL TRANSFER / PARTIAL REFUND/DISTRIBUTION

The PSPRS, CORP or EORP is directed to mail \$ _____ of my distribution to
(Fill in Amount)

(Name of Financial Institution) for deposit in accordance with the Rollover provisions.

The remainder of the taxable portion, less any applicable withholding described in the Special Tax Notice received with this election form (20% Federal Withholding) and the non-taxable portion will be paid directly to me.

Signature of Member

Date

If Option B or C is selected, THE FINANCIAL INSTITUTION MUST COMPLETE Agreement of Depository Trustee on Page 2. Also, please refer to Page 2 for mailing instructions.

To be completed by Financial Institution of the eligible Retirement Plan or IRA.

AGREEMENT OF DEPOSITORY TRUSTEE

In accordance with the authorization of the depositor on the front of this form, we agree to deposit the forthcoming rollover amount from the PSPRS, CORP or EORP in the following type of account:

(Check one)

- ____1) Section 401(a) Qualified Defined Benefit Plan
- ____2) Section 401(a) Qualified Defined Contribution Plan (includes Section 401K)
- ____3) Section 403(a) Qualified Annuity Plan
- ____4) Section 403(b) Tax Sheltered Annuity
- ____5) Section 408(a) Traditional IRA (includes SEP IRA)
- ____6) Section 408(b) Individual Retirement Annuity
- ____7) Section 457 Governmental Deferred Compensation Plan

Member's Name: _____

Account Number: _____

The following portion must be completed by a representative of the financial institution (not the member).

Name of Financial Institution (Trustee)

Authorized Signature

Mailing Address

Date

City State Zip

Return to: Board of Trustees
c/o Public Safety Personnel Retirement System
Corrections Officer Retirement Plan
Elected Officials Retirement Plan
3010 E Camelback RD, Suite 200
Phoenix Arizona 85016-4416

Corrections Officer Retirement Plan Retirement Instruction Manual

A manual of instructions, checklists and guidelines for completing normal, survivor's, and disability retirements in the Corrections Officer Retirement Plan.

NORMAL RETIREMENT CHECKLIST	2
DEFERRED ANNUITY CHECKLIST	7
REVERSE DROP CHECKLIST	10
SURVIVOR'S/GUARDIAN'S RETIREMENT CHECKLIST	16
DEATH BENEFICIARY CHECKLIST.....	22
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DISABILITY PROCEDURE	30
TOTAL AND PERMANENT DISABILITY MEMORANDUM.....	33
DUE PROCESS GUIDELINES FOR DISABILITY REHEARINGS.....	34
A GUIDE TO PROCESSING AN ACCIDENTAL, TOTAL AND PERMANENT, OR AN ORDINARY DISABILITY RETIREMENT.....	36

CORRECTIONS OFFICER RETIREMENT PLAN

NORMAL RETIREMENT CHECKLIST

Forms and Documentation Required

- | | |
|---|--|
| Form C4 | Copy of Member's Birth Certificate |
| Form 8 (Optional) | If Married: |
| Form C11 or | Copy of Spouse's Birth Certificate |
| Form C11A (if applicable) | Copy of Marriage Certificate |
| Form C12 | If Eligible Children: |
| Form 13 | Copy of Children's Birth Certificates |
| Federal Tax Withholding Preference Certificate
(Form W-4P) | Medical Documentation for Disabled Children (If applicable) |
| State Tax Withholding Preference Certificate
(Form A-4P) | If Divorced during period of employment: |
| Minutes from Local Board Approving Retirement | Photocopy of complete Divorce Decree, or
Certified copy of Plan-approved Domestic Relations Order |

IMPORTANT DEADLINE

To ensure sufficient time for processing for timely payment of retirement benefits, all applications must be received by the Board of Trustee's Administrative Office by the 10th of the month in which the retiree will receive their first benefit payment. For example, if a retiree's last day of work is in July, their retirement becomes effective August 1st and their retirement application should be submitted to the board of trustees no later than August 10th. Information should be double checked for accuracy before submitting the application. Please note, a Local Board meeting must be conducted prior to the submission of the Normal Retirement packet in order for our office to make payments effective in our system.

Form C4 - Application for Normal Retirement

Make sure this form is completely filled out, including necessary signatures. The retirement date on this form should agree with the member's last day of work or the date in which the member meets the minimum requirements for a normal retirement at time of termination; namely, 20 or more years of service, age 62 with 10 or more years of service or the eighty-point rule.

Form 8 - Beneficiary Designation Form (Optional)

Retirement is a critical time for members to update their beneficiary information. Many members are surprised to find who we have listed as their beneficiaries (ex-spouses, deceased parents, etc.), so we would encourage retirees to submit this form along with their retirement applications, to ensure that all benefit payments are made to the correct person(s).

Form C11 - Benefit Calculations

Be sure to verify the final contribution amount to CORP.

Credited Service: In calculating the length of the member's credited service, make sure that you use the statutory definition of "Credited Service" in A.R.S. Section 38-881.11:

“...credited service transferred to the retirement plan from another retirement system or plan for public employees of this state, plus those compensated periods of service as a member of the retirement plan for which member contributions are on deposit in the fund.”

By definition, a "leave without pay" is not "credited service as a member of the retirement plan for which member contributions are on deposit in the fund" and therefore cannot be considered as credited service for purposes of computing a member's retirement benefit on this form. The "period" to be considered is a FULL pay period. Do not record individual days or hours as leave without pay. Any FULL pay period(s) where the member did not receive compensation and CORP did not receive contributions must be noted on the Form C4 and should be subtracted from the member's total service to come up with the length of credited service.

Average monthly salary: In calculating a retiree's average monthly salary, the current CORP statute allows the member to use a period of thirty-six (36) consecutive months of service in which the member received the highest salary within the last one hundred twenty (120) months of service. Average monthly salary means the aggregate amount of salary that is paid a member divided by the member's months of service if the member has less than 36 months of service.

These 36 months do not have to be calendar years. If the 36 months considered years include periods of non-paid or partially paid industrial leave, you should include "the salary the employee would have received in this job classification if the employee was not on industrial leave". Be careful in determining the 36 consecutive months of salary. If the member's last day of work was June 26, 2010, the beginning of the 36 month period ending on that date would be June 27, 2007, not June 26, 2007.

Benefit Calculations: For retirees who worked with the employer before the CORP joinder date of 1986 and who are retiring under the ASRS law, please use Form C11a for benefit calculations. Please note that the member must have worked with the employer prior to the employer's joinder date with CORP. If the member was hired after the employer's joinder date, Form C11a could not be used.

If benefits are being calculated using the prior statutes, please use the correct factor tables provided to determine the correct benefit amounts as indicated on the Form C11a.

If benefits are being calculated using the 80 point rule, please note the calculation formula will vary depending on how many years of credited service the member has and whether or not the member worked prior to 8/9/01. If the member worked prior to 8/9/01, the member is entitled to receive an amount equal to 2.5% of the average monthly salary times credited service (section G of Form C11). If the member worked after this date, then the formula used will be based on the years of credited service as outlined on Form C11 in sections D-F.

If benefit calculations are incorrect when submitted, a corrected Form C11 and a new Form C12 with the member's signature must be submitted before the first benefit check can be released to the retiree.

Form C12 - Notification of Benefits and Election

Make sure that you mark the type of benefit: Normal Retirement.

The "Date First Payment Due" should be the last business day of the next calendar month following the retiree's last day of employment. For example, if the retiree's last day of work is on December 23, 1989, the "Date First Payment Due" should be January 31, 1990.

Make sure the member initials the appropriate election line on the bottom section of the form and then signs the Election and Acceptance in the presence of a witness.

Form 13 - Authorization to Direct Deposit Benefit Payment

A retiree's first monthly benefit can be issued either in check form or by direct deposit, if the direct deposit authorization is received by the 10th of the month. The Direct Deposit option enables us to electronically transfer monthly benefits into a retiree's bank or credit union account. The check will be mailed to the retiree's address indicated on Form C4. The retiree may view the direct deposit notice on the Members Only section of our website at www.psprs.com.

Have the retiree complete Form 13 and attach a voided check for the bank or credit union account into which the benefits are to be deposited. This office relies on the retiree to provide correct routing and account information for the direct deposit and any incorrect information will result in a delay in the direct deposit.

Federal Tax Withholding Preference Certificate (Form W-4P)

With the enactment of the Tax Reform Act of 1986, CORP retirement benefits became taxable upon retirement except for a small percent monthly that is excludable as recapture of the retiree's after-tax contributions under rules established by the IRS.

The retiree has three options on this form:

Line 1 - No federal withholding will be deducted from the benefit check.

Line 2 - Federal withholding based on the retiree's marital status and claimed allowances will be deducted from the benefit check.

Line 3 - The amount of federal withholding will be the amount based on the retiree's marital status and claimed allowances plus the ADDITIONAL AMOUNT indicated on Line 3 over and above the amount calculated based on marital status and allowances. Retiree's must select a marital status and fill in the number of allowances in order to have an additional amount. Our office will not accept incomplete forms or forms that just have a flat dollar amount written in.

Please note that we are required by federal regulations to withhold based upon married status with 3 exemptions if we do not have a correctly completed form on file.

State Tax Withholding Preference Certificate (Form A-4P)

Legislative changes provide for state taxation of CORP retirement benefits in excess of \$2500 annually effective retroactive to tax year commencing January 1, 1989.

The retiree has 8 options on this form:

Line 1 – Check one option:

- An amount equal to zero point eight percent (0.8%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

- An amount equal to one point three percent (1.3%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

- An amount equal to one point eight percent (1.8%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

- An amount equal to two point seven percent (2.7%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

- An amount equal to three point six percent (3.6%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

- An amount equal to four point two percent (4.2%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

- An amount equal to five point one percent (5.1%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

Line 2 - No State Withholding will be deducted from the benefit check.

Retirees must select a percentage in order to have an additional amount withheld. Our office will not accept incomplete forms or forms that just have a flat dollar amount written in.

Local Board Minutes Approving Retirement

The Local Board's initial authorization to the Board of Trustee's Administrative Office to pay retirement benefits is on Form C12 - Notification of Benefits and Election wherein the Local Board Chairman certifies that the Local Board "has met and determined that the applicant...is eligible for the benefit payment as shown above." This gives us the authority to issue the retiree's initial retirement benefit.

A.R.S. Section 38-893.G, provides "No later than twenty days after taking action, the local board shall submit to the board of trustees the minutes from the local board meeting that include the name of the member affected by its decision, a description of the action taken and an explanation of the reasons and documents supporting the local board's action.

In addition, A.R.S. Section 38-893.M., provides "The secretary of the local board shall keep a record and prepare minutes of all meetings in compliance with Chapter 3, Article 3.1 of this title and forward the minutes to the Board of trustees as prescribed by Subsection G of this section.

Health Insurance Plans and Subsidy Available to Retirees

Retiring Corrections Officer Retirement Plan (CORP) members and their eligible dependents may be eligible to enroll in one of the two State of Arizona retiree group health insurance programs which offer Medical and Dental coverage. The retiring member may also have an option to continue the coverage with their employer. The prospective retiree would need to contact their employer insurance liaison to find out if they are eligible.

The two State programs are:

1. The Benefits Options plan, this plan is administered by the Arizona Department of Administration (ADOA) and is available to any retiring members **whose employer is the state of Arizona**. Please note that ADOA only offers their coverage at the time of retirement and will not allow anyone who declines their coverage to join at a later date. A survivor is only eligible to take the ADOA coverage if the member was qualified for retirement before death or already receiving a monthly benefit and she is on the plan with the member at time of death.
2. The Arizona State Retirement System (ASRS) plan, this plan is administered by Arizona State Retirement System and is available to all CORP retirees. Enrollment is handled by the PSPRS office for their retirees. The ASRS plans are offered to survivors regardless of whether on the plan before death of member or not. Retirees may join this plan during any open enrollment period or qualified life event.

Information packets regarding available insurance coverage under these plans can be obtained by contacting the offices shown below:

The Department of Administration
Benefits Office
100 N. 15th Ave. #103
Phoenix, AZ 85007
Phone numbers:
(602)-542-5008
(800)-304-3687
Website: www.hr.state.az.us/benefits

Public Safety Personnel Retirement System
3010 E Camelback Rd., Suite 200
Phoenix, AZ 85016
Phone Number:
(602)-255-5575
Fax Number:
(602)-296-2370
Website: www.psprs.com

Health Insurance Premium Benefit (Subsidy)

State statute provides a subsidy from PSRPRS to retired members and survivors receiving a monthly retirement pension and who are enrolled in a qualified retiree health insurance programs from their employer or the state. The following table is a breakdown of the amounts available.

	Members Only		Member & Dependents		
	NOT MEDICARE ELIGIBLE	MEDICARE ELIGIBLE	ALL NOT MEDICARE ELIGIBLE	ALL MED. ELIGIBLE	ONE WITH MEDICARE
Elected Officials' Retirement Plan (EORP)					
5 – 5.9	\$90.00	\$60.00	\$156.00	\$102.00	\$129.00
6 – 6.9	\$112.50	\$75.00	\$195.00	\$127.50	\$161.25
7 – 7.9	\$135.00	\$90.00	\$234.00	\$153.00	\$193.50
8 – 8.9	\$150.00	\$100.00	\$260.00	\$170.00	\$215.00

Corrections Officer Retirement Plan (CORP)

not applicable	\$150.00	\$100.00	\$260.00	\$170.00	\$215.00
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Public Safety Personnel Retirement System (PSPRS)

not applicable	\$150.00	\$100.00	\$260.00	\$170.00	\$215.00
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Note that there are new provisions regarding the provision of health insurance by the employer to survivors of police officers, corrections officers or probation officers killed in the line of duty. The new statute follows.

Legislation from the State of Arizona
House of Representatives
Forty-ninth Legislature
Second Regular Session
2010

CHAPTER 148

HOUSE BILL 2296

38-1103. Health insurance payments for spouse or dependents of law enforcement officer killed in the line of duty; definition

A. NOTWITHSTANDING ANY OTHER LAW, THE SURVIVING SPOUSE OF A DECEASED LAW ENFORCEMENT OFFICER IS ENTITLED TO RECEIVE PAYMENTS FOR HEALTH INSURANCE PREMIUMS FROM PUBLIC MONIES OF THE EMPLOYER OF THE LAW ENFORCEMENT OFFICER FOR THE FIRST YEAR AFTER THE DEATH OF THE LAW ENFORCEMENT OFFICER IF:

1. THE LAW ENFORCEMENT OFFICER WAS KILLED IN THE LINE OF DUTY OR DIED FROM INJURIES SUFFERED IN THE LINE OF DUTY.
2. THE LAW ENFORCEMENT OFFICER WAS ENROLLED IN THE EMPLOYER'S HEALTH INSURANCE PLAN AT THE TIME OF DEATH.
3. THE SURVIVING SPOUSE IS ENTITLED TO CONTINUE TO PARTICIPATE IN THE EMPLOYER'S HEALTH INSURANCE PLAN.

B. THIS SECTION APPLIES TO THE DEPENDENTS OF THE DECEASED LAW ENFORCEMENT OFFICER IF THE DEPENDENTS WERE ENROLLED IN THE EMPLOYER'S HEALTH INSURANCE PLAN AT THE TIME OF THE LAW ENFORCEMENT OFFICER'S DEATH.

C. PAYMENTS SHALL BE REDUCED FOR MONIES PAID FOR HEALTH INSURANCE PREMIUMS FOR THE SURVIVING SPOUSE OR DEPENDENTS OF THE SURVIVING SPOUSE FROM THE RETIREMENT PLAN FROM WHICH THE SURVIVING SPOUSE IS RECEIVING BENEFITS.

D. FOR THE PURPOSES OF THIS SECTION, "LAW ENFORCEMENT OFFICER" MEANS:

1. A PEACE OFFICER WHO IS CERTIFIED BY THE ARIZONA PEACE OFFICERS STANDARDS AND TRAINING BOARD.
2. A DETENTION OFFICER OR CORRECTIONS OFFICER WHO IS EMPLOYED BY THIS STATE OR A POLITICAL SUBDIVISION OF THIS STATE.
3. A PROBATION OFFICER OR SURVEILLANCE OFFICER WHO IS EMPLOYED BY THIS STATE OR A POLITICAL SUBDIVISION OF THIS STATE.

Sec. 3. Short title

This act may be cited as "Harrolle's Law".

Sec. 4. Retroactivity

This act is effective retroactively to from and after December 31, 2009.

Sec. 5. Emergency

This act is an emergency measure that is necessary to preserve the public peace, health or safety and is operative immediately as provided by law.

APPROVED BY THE GOVERNOR APRIL 26, 2010.

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 27, 2010.

CORRECTIONS OFFICER RETIREMENT PLAN

DEFERRED ANNUITY CHECKLIST

Forms and Documentation Required

- | | |
|---|--|
| Form C4D | Copy of Applicant's Birth Certificate |
| Form C8 (Optional) | If Married: |
| Deferred Annuity Calculation | Copy of Spouse's Birth Certificate |
| Form C12 | Copy of Marriage Certificate |
| Form 13 | If Eligible Children: |
| Federal Tax Withholding Preference Certificate
(Form W-4P) | Copy of Children's Birth Certificates |
| State Tax Withholding Preference Certificate
(Form A-4P) | If Divorced during period of employment: |
| Minutes from Local Board Approving Annuity | Photocopy of complete Divorce Decree, or |
| | Certified copy of Plan-approved Domestic Relations Order |

IMPORTANT DEADLINE

To ensure sufficient time for processing for timely payment of annuity benefits, all applications must be received by the Board of Trustee's Administrative Office by the 10th of the month in which the applicant will receive their first annuity payment. Please note, a Local Board meeting must be conducted prior to the submission of the Deferred Annuity packet in order for our office to make payments effective in our system.

Form C4D - Application for Deferred Annuity

Make sure this application is completely filled out, including necessary signatures. Attach copies of the supporting documentation as required on the C4D.

Form 8 - Beneficiary Designation Form (Optional)

The Deferred Annuity option does not offer surviving spouse or child benefits, however, if there are any contributions left on account at the time of death, a named beneficiary would be paid the remaining balance of the contributions as outlined in the statutes.

Deferred Annuity Calculation

In order to calculate a Deferred Annuity, the electronic retirement spreadsheets **MUST** be used due to the factors used in computing age, credited service time, and total contributions made by the member. The spreadsheets are located at www.psprs.com under the CORP Employer menu and by selecting "Spreadsheets". Select the "Retirement Forms" spreadsheet and fill in the Input Sheet with the required data.

Any periods of leave without pay or industrial leave should be noted and taken into consideration when computing credited service and the annuity benefit when filling in the required fields in the Deferred Annuity spreadsheet located at www.psprs.com under the CORP Employer menu in "Spreadsheets".

By definition, a "leave without pay" is not a "compensated period of service" and therefore cannot be considered as credited service for purposes of computing a member's annuity on this form. The "period" to be considered is a FULL pay period. Do not record individual days or hours as leave without pay. Any FULL pay period(s) where the member did not receive compensation and CORP did not receive contributions must be noted on the Form C4D and should be subtracted from the member's total service to come up with the length of credited service.

Form C12 - Notification of Benefits and Election

The Type of Benefit should reflect: Deferred Annuity

The "Date First Payment Due" should be the last business day of the next calendar month following the date of application.

Make sure the applicant initials the appropriate election line (first option) on the bottom section of the form and then signs the Election and Acceptance in the presence of a witness.

Form 13 - Authorization to Direct Deposit Annuity Payment

Annuity payments can be issued either in check form or by direct deposit, if the direct deposit authorization is received by the 10th of the month. The Direct Deposit option enables us to electronically transfer monthly benefits into a member's bank or credit union account. The check will be mailed to the member's address indicated on Form C4D. The member may view the direct deposit notice on the Members Only section of our website at www.psprs.com.

Have the applicant complete Form 13 and attach a voided check for the bank or credit union account into which the annuity benefits are to be deposited. This office relies on the applicant to provide correct routing and account information and any incorrect information may result in a delay in the direct deposit.

Federal Tax Withholding Preference Certificate (Form W-4P)

With the enactment of the Tax Reform Act of 1986, CORP retirement benefits became taxable upon retirement except for a small percent monthly that is excludable as recapture of the retiree's after-tax contributions under rules established by the IRS.

The applicant has three options on this form:

Line 1 - No federal withholding will be deducted from the benefit check.

Line 2 - Federal withholding based on the retiree's marital status and claimed allowances will be deducted from the benefit check.

Line 3 - The amount of federal withholding will be the amount based on the retiree's marital status and claimed allowances plus the ADDITIONAL AMOUNT indicated on Line 3 over and above the amount calculated based on marital status and allowances. Applicants must select a marital status and fill in the number of allowances in order to have an additional amount. Our office will not accept incomplete forms or forms that just have a flat dollar amount written in.

Please note that we are required by federal regulations to withhold based upon married status with 3 exemptions if we do not have a correctly completed form on file.

State Tax Withholding Preference Certificate (Form A-4P)

Legislative changes provide for state taxation of PSPRS retirement benefits in excess of \$2500 annually effective retroactive to tax year commencing January 1, 1989.

The applicant has 8 options on this form:

Line 1 – Check one option:

- An amount equal to zero point eight percent (0.8%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

- An amount equal to one point three percent (1.3%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

- An amount equal to one point eight percent (1.8%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

- An amount equal to two point seven percent (2.7%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to three point six percent (3.6%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to four point two percent (4.2%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to five point one percent (5.1%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

Line 2 - No State Withholding will be deducted from the benefit check.

Applicants must select a percentage in order to have an additional amount withheld. Our office will not accept incomplete forms or forms that just have a flat dollar amount written in.

Local Board Minutes Approving Deferred Annuity

The Local Board's initial authorization to the Board of Trustee's Administrative Office to pay retirement benefits is on Form C12 - Notification of Benefits and Election wherein the Local Board Chairman certifies that the Local Board "has met and determined that the applicant...is eligible for the benefit payment as shown above." This gives us the authority to issue the applicant's initial annuity payment.

A.R.S. Section 38-893.G, provides "No later than twenty days after taking action, the local board shall submit to the board of trustees the minutes from the local board meeting that include the name of the member affected by its decision, a description of the action taken and an explanation of the reasons and documents supporting the local board's action.

In addition, A.R.S. Section 38-893.M., provides "The secretary of the local board shall keep a record and prepare minutes of all meetings in compliance with Chapter 3, Article 3.1 of this title and forward the minutes to the Board of trustees as prescribed by Subsection G of this section.

Special Notice about Deferred Annuity

The Deferred Annuity is not a retirement benefit and annuitant's are not entitled to receive any amount prescribed by sections 38-887, 38-888, 38-904, 38-905, 38-905.02 or 38-906.

CORRECTIONS OFFICER RETIREMENT PLAN

REVERSE DROP CHECKLIST

Forms and Documentation Required

- | | |
|---|---|
| Form C4 RDROP | Retirement Verification of Final Contributions to CORP |
| Form C8 RDROP | Copy of Member's Birth Certificate |
| Form C11 RDROP | If Married: |
| Form C12 RDROP | Copy of Spouse's Birth Certificate |
| Form 13 | Copy of Marriage Certificate |
| Form U3 Benefits Lump Sum Distribution Election | If Eligible Children: |
| Special Tax Notice (copy to retiree) | Copy of Children's Birth Certificates |
| Federal Tax Withholding Preference Certificate | Medical Documentation for Disabled Children (If applicable) |
| (Form W-4P) | If Divorced during period of employment: |
| State Tax Withholding Preference Certificate | Photocopy of complete Divorce Decree, or |
| (Form A-4P) | Certified copy of Plan-approved Domestic Relations Order |
| Memorandum and Understanding and Agreement | |
| Minutes from Local Board Approving Reverse DROP | |

IMPORTANT DEADLINE

To ensure sufficient time for processing for timely payment of retirement benefits, all applications must be received by the Board of Trustee's Administrative Office by the 10th of the month in which the retiree will receive their first benefit payment. For example, if a retiree's last day of work is in July, their retirement becomes effective August 1st and their retirement application should be submitted to the board of trustees no later than August 10th. Information should be double checked for accuracy before submitting the application. Please note, a Local Board meeting must be conducted prior to the submission of the Reverse DROP packet in order for our office to make participation effective in our system.

Form C4RDROP - Application for Reverse DROP

Make sure this form is completely filled out on both sides, including necessary signatures. The date of election to participate in Reverse DROP should agree with the retirement date. The Reverse DROP date should agree with the ending service date on the Form C11RDROP. The member elects a Reverse DROP date that is the first day of the month immediately following completion of 24 years of credited service (25 years of credited service required for dispatchers) or a date not more than 60 consecutive months before the date the member elects to participate in the Reverse DROP, whichever is later. Any leaves without pay or industrial leaves should be noted and taken into consideration when computing credited service and the Reverse DROP benefit on the Form C11RDROP. Remember that leaves without pay will affect one's credited service amount.

Form C8RDROP – Beneficiary Designation

The designated beneficiary is entitled to receive the Reverse DROP monies if the member dies after making application but before receiving the first payment. If no designation were made, the estate would get the monies. If a person other than the spouse is listed, the spouse must also sign the document with the appropriate witness. If the spouse does not sign the document, the prescribed designated beneficiary will still be effective; however, if there were a dispute, it would be between the spouse and the designated beneficiary.

Form C11RDROP - Benefit Calculations

Be sure to verify the final contribution amount to CORP.

Credited Service: In calculating the length of the member's credited service, make sure that you use the statutory definition of "Credited Service" in A.R.S. Section 38-881.11:

“...credited service transferred to the retirement plan from another retirement system or plan for public employees of this state, plus those compensated periods of service as a member of the retirement plan for which member contributions are on deposit in the fund.”

By definition, a "leave without pay" is not "credited service as a member of the retirement plan for which member contributions are on deposit in the fund" and therefore cannot be considered as credited service for purposes of computing a member's retirement benefit on this form. The "period" to be considered is a FULL pay period. Do not record individual days or hours as leave without pay. Any FULL pay period(s) where the member did not receive compensation and CORP did not receive contributions must be noted on the Form C4RDROP and should be subtracted from the member's total service to come up with the length of credited service.

Average monthly salary: In calculating a retiree's average monthly salary, the current CORP statute allows the member to use a period of thirty-six (36) consecutive months of service in which the member received the highest salary within the last one hundred twenty (120) months of service. Average monthly salary means the aggregate amount of salary that is paid a member divided by the member's months of service if the member has less than thirty-six months of service.

These 36 months do not have to be calendar years. Be careful in determining the 36 consecutive months of compensation. If the member's last day of work was June 26, 2010, the beginning of the 36 month period ending on that date would be June 27, 2007, not June 26, 2007.

Benefit Calculations: Make sure that you use the correct section of Form C11RDROP to calculate the appropriate benefit calculation for each individual Reverse DROP applicant.

For retirement with 24 or more years of credited service: Use Section D.

For retirement with 25 or more years of credited service: Use Section E.

If benefit calculations are incorrect when submitted, a corrected Form C11RDROP and a new Form C12RDROP with the member's signature must be submitted before the lump sum Reverse DROP payment check and first pension benefit can be released to the retiree.

If benefits are being calculated using the prior statutes, please use the correct factor tables provided to determine the correct benefit amounts.

Form C12RDROP - Notification of Reverse DROP Benefits and Election

The "Date First Reverse DROP Benefit Credited" should be the first day of the month following the Reverse DROP date. The "Date Last Reverse DROP Benefit Credited" is the first day of the month of retirement.

For example:

Date Elected to Participate: 09/30/2008 (this is the retirement date)
Service Dates: 03/15/1979 to 9/30/2008
Reverse DROP Date = 10/01/2003

Date First Reverse DROP Benefit Credited: 10/01/2003
Date Last Reverse DROP Benefit Credited: 09/30/2008

If the member's Reverse DROP date was 10/1/2003, the beginning of the 3 year period ending on that date would be 10/2/2000, not 10/1/2000. The 60 months the member has chosen to participate in Reverse DROP is not considered in the calculation of the member's monthly benefit amount.

Make sure the Reverse DROP applicant initials the election line on the bottom section of the form and then signs the Election and Acceptance in the presence of a witness.

Form 13 - Authorization to Direct Deposit Benefit Payment

A retiree's first monthly benefit can be issued either in check form or by direct deposit, if the direct deposit authorization is received by the 10th of the month. The Direct Deposit option enables us to electronically transfer monthly benefits into a retiree's bank or credit union account. The check will be mailed to the retiree's address indicated on Form C4RDROP. The retiree may view the direct deposit notice on the Members Only section of our website at www.psprs.com.

Have the retiree complete Form 13 and attach a voided check for the bank or credit union account into which the benefits are to be deposited. This office relies on the retiree to provide correct routing and account information for the direct deposit and any incorrect information will result in a delay in the direct deposit.

Form U3 – Benefits Lump Sum Distribution Election Form

Without Form U3 Benefits, the retirement cannot be processed. Any references to a 30-day grace period for submission of this form are false. Members and Local Board staff are not authorized to sign in place of the Financial Institution Representative or have the rollover check mailed directly to them on page 2 of the Form U3 Benefits.

If the retiree elects to rollover the monies to a qualified IRA account, then a check will be mailed to the address as indicated on the Form U3 Benefits page 2. Our office is currently in the process of setting up the option to direct deposit rollover monies. The Form U3 Benefits page 2 will be updated once this option is available.

Special Tax Notice

Provide a copy of the Special Tax Notice to the retiree.

Federal Tax Withholding Preference Certificate (Form W-4P)

With the enactment of the Tax Reform Act of 1986, CORP retirement benefits became taxable upon retirement except for a small percent monthly that is excludable as recapture of the retiree's after-tax contributions under rules established by the IRS.

The retiree has three options on this form:

Line 1 - No federal withholding will be deducted from the benefit check.

Line 2 - Federal withholding based on the retiree's marital status and claimed allowances will be deducted from the benefit check.

Line 3 - The amount of federal withholding will be the amount based on the retiree's marital status and claimed allowances plus the ADDITIONAL AMOUNT indicated on Line 3 over and above the amount calculated based on marital status and allowances. Retirees must select a marital status and fill in the number of allowances in order to have an additional amount. Our office will not accept incomplete forms or forms that just have a flat dollar amount written in.

Please note that we are required by federal regulations to withhold based upon married status with 3 exemptions if we do not have a correctly completed form on file.

State Tax Withholding Preference Certificate (Form A-4P)

Legislative changes provide for state taxation of PSPRS retirement benefits in excess of \$2500 annually effective retroactive to tax year commencing January 1, 1989.

The retiree has 8 options on this form:

Line 1 – Check one option:

- An amount equal to zero point eight percent (0.8%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to one point three percent (1.3%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to one point eight percent (1.8%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to two point seven percent (2.7%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to three point six percent (3.6%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to four point two percent (4.2%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to five point one percent (5.1%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

Line 2 - No State Withholding will be deducted from the benefit check.

Retirees must select a percentage in order to have an additional amount withheld. Our office will not accept incomplete forms or forms that just have a flat dollar amount written in.

Reverse DROP Memorandum of Understanding and Agreement

Make sure the employee initials all of the statements and that the employer signs the memo. Provide a copy of the Reverse DROP laws to the employee and the employer. This is important for the employer, as they need to adjust their payroll records to terminate the employer and employee contributions to CORP.

Local Board Minutes Approving Retirement

The Local Board's initial authorization to the Board of Trustee's Administrative Office to pay retirement benefits is on Form C12RDROP - Notification of Benefits and Election wherein the Local Board Chairman certifies that the Local Board "has met and determined that the applicant...is eligible for the benefit payment as shown above." This gives us the authority to issue the retiree's initial retirement benefit.

A.R.S. Section 38-893.G, provides "No later than twenty days after taking action, the local board shall submit to the board of trustees the minutes from the local board meeting that include the name of the member affected by its decision, a description of the action taken and an explanation of the reasons and documents supporting the local board's action.

In addition, A.R.S. Section 38-893.M., provides "The secretary of the local board shall keep a record and prepare minutes of all meetings in compliance with Chapter 3, Article 3.1 of this title and forward the minutes to the Board of trustees as prescribed by Subsection G of this section.

Health Insurance Plans and Subsidy Available to Retirees

Retiring Corrections Officer Retirement Plan (CORP) members and their eligible dependents may be eligible to enroll in one of the two State of Arizona retiree group health insurance programs which offer Medical and Dental coverage. The retiring member may also have an option to continue the coverage with their employer. The prospective retiree would need to contact their employer insurance liaison to find out if they are eligible.

The two State programs are:

1. The Benefits Options plan, this plan is administered by the Arizona Department of Administration (ADOA) and is available to any retiring members **whose employer is the state of Arizona**. Please note that ADOA only offers their coverage at the time of retirement and will not allow anyone who declines their coverage to join at a later date. A survivor is only eligible to take the ADOA coverage if the member was qualified for retirement before death or already receiving a monthly benefit and she is on the plan with the member at time of death.

2. The Arizona State Retirement System (ASRS) plan, this plan is administered by Arizona State Retirement System and is available to all CORP retirees. Enrollment is handled by the PSPRS office for their retirees. The ASRS plans are offered to survivors regardless of whether on the plan before death of member or not. Retirees may join this plan during any open enrollment period or qualified life event.

Information packets regarding available insurance coverage under these plans can be obtained by contacting the offices shown below:

The Department of Administration
Benefits Office
100 N. 15th Ave. #103
Phoenix, AZ 85007
Phone numbers:
(602)-542-5008
(800)-304-3687
Website: www.hr.state.az.us/benefits

Public Safety Personnel Retirement System
3010 E Camelback Rd., Suite 200
Phoenix, AZ 85016
Phone Number:
(602)-255-5575
Fax Number:
(602)-296-2370
Website: www.psprs.com

Health Insurance Premium Benefit (Subsidy)

State statute provides a subsidy from PSRPRS to retired members and survivors receiving a monthly retirement pension and who are enrolled in a qualified retiree health insurance programs from their employer or the state. The following table is a breakdown of the amounts available.

	Members Only		Member & Dependents		
	NOT MEDICARE ELIGIBLE	MEDICARE ELIGIBLE	ALL NOT MEDICARE ELIGIBLE	ALL MED. ELIGIBLE	ONE WITH MEDICARE
Elected Officials' Retirement Plan (EORP)					
5 – 5.9	\$90.00	\$60.00	\$156.00	\$102.00	\$129.00
6 – 6.9	\$112.50	\$75.00	\$195.00	\$127.50	\$161.25
7 – 7.9	\$135.00	\$90.00	\$234.00	\$153.00	\$193.50
8 – 8.9	\$150.00	\$100.00	\$260.00	\$170.00	\$215.00
Corrections Officer Retirement Plan (CORP)					
not applicable	\$150.00	\$100.00	\$260.00	\$170.00	\$215.00
Public Safety Personnel Retirement System (PSPRS)					
not applicable	\$150.00	\$100.00	\$260.00	\$170.00	\$215.00

Note that there are new provisions regarding the provision of health insurance by the employer to survivors of police officers, corrections officers or probation officers killed in the line of duty. The new statute follows.

Legislation from the State of Arizona
House of Representatives
Forty-ninth Legislature
Second Regular Session
2010

CHAPTER 148

HOUSE BILL 2296

38-1103. Health insurance payments for spouse or dependents of law enforcement officer killed in the line of duty; definition

A. NOTWITHSTANDING ANY OTHER LAW, THE SURVIVING SPOUSE OF A DECEASED LAW ENFORCEMENT OFFICER IS ENTITLED TO RECEIVE PAYMENTS FOR HEALTH INSURANCE PREMIUMS FROM PUBLIC MONIES OF THE EMPLOYER OF THE LAW ENFORCEMENT OFFICER FOR THE FIRST YEAR AFTER THE DEATH OF THE LAW ENFORCEMENT OFFICER IF:

1. THE LAW ENFORCEMENT OFFICER WAS KILLED IN THE LINE OF DUTY OR DIED FROM INJURIES SUFFERED IN THE LINE OF DUTY.
2. THE LAW ENFORCEMENT OFFICER WAS ENROLLED IN THE EMPLOYER'S HEALTH INSURANCE PLAN AT THE TIME OF DEATH.
3. THE SURVIVING SPOUSE IS ENTITLED TO CONTINUE TO PARTICIPATE IN THE EMPLOYER'S HEALTH INSURANCE PLAN.

B. THIS SECTION APPLIES TO THE DEPENDENTS OF THE DECEASED LAW ENFORCEMENT OFFICER IF THE DEPENDENTS WERE ENROLLED IN THE EMPLOYER'S HEALTH INSURANCE PLAN AT THE TIME OF THE LAW ENFORCEMENT OFFICER'S DEATH.

C. PAYMENTS SHALL BE REDUCED FOR MONIES PAID FOR HEALTH INSURANCE PREMIUMS FOR THE SURVIVING SPOUSE OR DEPENDENTS OF THE SURVIVING SPOUSE FROM THE RETIREMENT PLAN FROM WHICH THE SURVIVING SPOUSE IS RECEIVING BENEFITS.

D. FOR THE PURPOSES OF THIS SECTION, "LAW ENFORCEMENT OFFICER" MEANS:

1. A PEACE OFFICER WHO IS CERTIFIED BY THE ARIZONA PEACE OFFICERS STANDARDS AND TRAINING BOARD.
2. A DETENTION OFFICER OR CORRECTIONS OFFICER WHO IS EMPLOYED BY THIS STATE OR A POLITICAL SUBDIVISION OF THIS STATE.
3. A PROBATION OFFICER OR SURVEILLANCE OFFICER WHO IS EMPLOYED BY THIS STATE OR A POLITICAL SUBDIVISION OF THIS STATE.

Sec. 3. Short title

This act may be cited as "Harrolle's Law".

Sec. 4. Retroactivity

This act is effective retroactively to from and after December 31, 2009.

Sec. 5. Emergency

This act is an emergency measure that is necessary to preserve the public peace, health or safety and is operative immediately as provided by law.

APPROVED BY THE GOVERNOR APRIL 26, 2010.

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 27, 2010.

**CORRECTIONS OFFICER RETIREMENT PLAN
SURVIVOR'S/GUARDIAN'S RETIREMENT CHECKLIST**

Forms and Documentation Required

Form C7	
Form C8 (Optional)	Copy of Member's Death Certificate
Form C11	Copy of Survivor's/Guardian's Birth Certificate
Form C12	Copy of Marriage Certificate (If applicable)
Form 13	Copy of Survivor's/Guardian's Social Security Card
Form C14 (if applicable)	If Eligible Children:
Federal Tax Withholding Preference Certificate Form W-4P	Copy of Children's Birth Certificates
State Tax Withholding Preference Certificate Form A-4P	Medical Documentation for Disabled Children (If applicable)
Minutes from Local Board Approving Survivor's Retirement and Terminating Member's Pension	Proof of Full-time School Enrollment (If applicable)
	Proof of Legal Guardianship (if applicable)

IMPORTANT DEADLINE

To ensure sufficient time for processing for timely payment of retirement benefits, all applications must be received by the Board of Trustee's Administrative Office by the 10th of the month in which the survivor/guardian will receive their first benefit payment. For example, if a retiree's date of death is in July, the survivor/guardian retirement becomes effective August 1st and the retirement application should be submitted to the board of trustees no later than August 10th. Information should be double checked for accuracy before submitting the application. Please note, a Local Board meeting must be conducted prior to the submission of the Survivor/Guardian Benefit packet in order for our office to make payments effective in our system.

Form C7 - Application for a Survivor's Benefit

Make sure this form is completely filled out, including the necessary signatures.

SURVIVING SPOUSE: The CORP statute prescribes the following eligibility requirements for a Surviving Spouse Benefit:

- a) Surviving Spouse of a deceased active, (non-retired) member - the applicant must be the legal spouse of the active member at the time of the member's death.
- b) Surviving Spouse of a deceased retired member - the applicant must be the legal spouse of the retired member at the time of the member's death and said marriage must have been for a period of at least two years prior to the retired member's date of death.

The State of Arizona does not recognize common-law marriages and neither will the CORP. A divorce or annulment in progress at the time of death will not affect the surviving spouse's rights to benefits unless they have become final prior to the member's death.

GUARDIAN/CHILD'S BENEFIT: The applicant must be the legally-appointed guardian or custodian of the deceased member's eligible child as defined in A.R.S. Section 38-881.19:

- "Eligible Child" means an unmarried child of a deceased active or retired member who meets one of the following qualifications:
- (a) Is under eighteen years of age
 - (b) Is at least eighteen years of age and under twenty-three years of age only during any period that the child is full-time student.
 - (c) Is under a disability that began before the child attained twenty-three years of age and remains a dependent of the surviving spouse or guardian.

An eligible child must be the natural offspring of the member or legally adopted by the member. The applicant must show proof of adoption. Pursuant to section 38-904.B a child's pension terminates if the child is adopted.

A guardian/child's pension is payable only if there is no eligible surviving spouse receiving Survivor's Benefits.

Form C11 - Benefit Calculations

FOR DECEASED RETIRED MEMBERS:

For deceased members already receiving normal service retirement benefits, or disability retirement benefits, you will not need to recalculate the member's pension. Complete the top section, giving the identification and service information on the deceased member, and indicate the deceased member's monthly benefit at the time of death on Line D.3, E.3, F G, or H whichever is applicable. The Surviving Spouse or Guardian/Child's pension is calculated on Line I.

If you are unsure of the monthly pension being received by a retired member at the time of death, contact the Administrative Office and ask for the Benefits Department.

FOR DECEASED ACTIVE (NON-RETIRED) MEMBERS:

Pursuant to A.R.S. Section 38-888, the surviving spouse of a deceased active member shall receive a monthly benefit that is 40% of the deceased member's average monthly salary.

Please note: In calculating the credited service and average monthly benefit compensation for deceased active members, follow the guidelines for credited service and compensation contained in the Normal Retirement Checklist. Be sure to verify the final contribution amount to CORP.

If benefit calculations are incorrect when submitted, a corrected Form C11 and a new Form C12 with the member's signature must be submitted before the first benefit check can be released to the retiree.

Form C12 - Notification of Benefits and Election

The CORP member's name should go in the space requesting the "Member's Name" with the Surviving Spouse's name listed on the line requesting "Payable To".

Make sure that you mark the Type of Benefit "Survivor".

The "Date First Payment Due" should be the last business day of the next calendar month following the date of death. For example, if the member died on December 23, 1989, the "Date of First Payment Due" should be January 31, 1990.

Make sure the survivor initials the appropriate election line on the bottom section of the form and then signs the Election and Acceptance in the presence of a witness.

Form 13 - Authorization to Direct Deposit Benefit Payment

A survivor's/guardian's first monthly benefit can be issued either in check form or by direct deposit, if the direct deposit authorization is received by the 10th of the month. The Direct Deposit option enables us to electronically transfer monthly benefits into a survivor's bank or credit union account. The check will be mailed to the survivor's address indicated on Form C7. The survivor may view the direct deposit notice on the Members Only section of our website at www.psprs.com.

Have the survivor complete Form 13 and attach a voided check for the bank or credit union account into which the benefits are to be deposited. This office relies on the survivor to provide correct routing and account information for the direct deposit and any incorrect information will result in a delay in the direct deposit.

Form 14 - Certification of Marital Status

This form must be completed if the survivor is not able to produce a copy of the marriage certificate. Make sure the survivor fills out this form completely and signs it in front of a notary.

Federal Tax Withholding Preference Certificate (Form W-4P)

With the enactment of the Tax Reform Act of 1986, CORP retirement benefits became taxable upon retirement except for a small percent monthly that is excludable as recapture of the retiree's after-tax contributions under rules established by the IRS.

The survivor/guardian has three options on this form:

Line 1 - No federal withholding will be deducted from the benefit check.

Line 2 - Federal withholding based on the survivor's marital status and claimed allowances will be deducted from the benefit check.

Line 3 - The amount of federal withholding will be the amount based on the retiree's marital status and claimed allowances plus the ADDITIONAL AMOUNT indicated on Line 3 over and above the amount calculated based on marital status and allowances. Survivors/Guardians must select a marital status and fill in the number of allowances in order to have an additional amount. Our office will not accept incomplete forms or forms that just have a flat dollar amount written in.

Please note that we are required by federal regulations to withhold based upon married status with 3 exemptions if we do not have a correctly completed form on file.

State Tax Withholding Preference Certificate (Form A-4P)

Legislative changes provide for state taxation of PSPRS retirement benefits in excess of \$2500 annually effective retroactive to tax year commencing January 1, 1989.

The survivor/guardian has 8 options on this form:

Line 1 – Check one option:

- An amount equal to zero point eight percent (0.8%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

- An amount equal to one point three percent (1.3%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

- An amount equal to one point eight percent (1.8%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

- An amount equal to two point seven percent (2.7%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

- An amount equal to three point six percent (3.6%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

- An amount equal to four point two percent (4.2%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

- An amount equal to five point one percent (5.1%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

Line 2 - No State Withholding will be deducted from the benefit check.

Survivors/Guardians must select a percentage in order to have an additional amount withheld. Our office will not accept incomplete forms or forms that just have a flat dollar amount written in.

Local Board Minutes Approving Retirement

The Local Board's initial authorization to the Board of Trustee's Administrative Office to pay retirement benefits is on Form C12 - Notification of Benefits and Election wherein the Local Board Chairman certifies that the Local Board "has met and determined that the applicant...is eligible for the benefit payment as shown above." This gives us the authority to issue the survivor's/guardian's initial retirement benefit.

A.R.S. Section 38-893.G, provides "No later than twenty days after taking action, the local board shall submit to the board of trustees the minutes from the local board meeting that include the name of the member affected by its decision, a description of the action taken and an explanation of the reasons and documents supporting the local board's action.

In addition, A.R.S. Section 38-893.M., provides "The secretary of the local board shall keep a record and prepare minutes of all meetings in compliance with Chapter 3, Article 3.1 of this title and forward the minutes to the Board of trustees as prescribed by Subsection G of this section.

Health Insurance Plans and Subsidy Available to Retirees

Retiring Corrections Officer Retirement Plan (CORP) members and their eligible dependents may be eligible to enroll in one of the two State of Arizona retiree group health insurance programs which offer Medical and Dental coverage. The retiring member may also have an option to continue the coverage with their employer. The prospective retiree would need to contact their employer insurance liaison to find out if they are eligible.

The two State programs are:

1. The Benefits Options plan, this plan is administered by the Arizona Department of Administration (ADOA) and is available to any retiring members **whose employer is the state of Arizona**. Please note that ADOA only offers their coverage at the time of retirement and will not allow anyone who declines their coverage to join at a later date. A survivor is only eligible to take the ADOA coverage if the member was qualified for retirement before death or already receiving a monthly benefit and she is on the plan with the member at time of death.
2. The Arizona State Retirement System (ASRS) plan, this plan is administered by Arizona State Retirement System and is available to all CORP retirees. Enrollment is handled by the PSPRS office for their retirees. The ASRS plans are offered to survivors regardless of whether on the plan before death of member or not. Retirees may join this plan during any open enrollment period or qualified life event.

Information packets regarding available insurance coverage under these plans can be obtained by contacting the offices shown below:

The Department of Administration
Benefits Office
100 N. 15th Ave. #103
Phoenix, AZ 85007
Phone numbers:
(602)-542-5008
(800)-304-3687
Website: www.hr.state.az.us/benefits

Public Safety Personnel Retirement System
3010 E Camelback Rd., Suite 200
Phoenix, AZ 85016
Phone Number:
(602)-255-5575
Fax Number:
(602)-296-2370
Website: www.psprs.com

Health Insurance Premium Benefit (Subsidy)

State statute provides a subsidy from PSRPRS to retired members and survivors receiving a monthly retirement pension and who are enrolled in a qualified retiree health insurance programs from their employer or the state. The following table is a breakdown of the amounts available.

	Members Only		Member & Dependents		
	NOT MEDICARE ELIGIBLE	MEDICARE ELIGIBLE	ALL NOT MEDICARE ELIGIBLE	ALL MED. ELIGIBLE	ONE WITH MEDICARE
Elected Officials' Retirement Plan (EORP)					
5 - 5.9	\$90.00	\$60.00	\$156.00	\$102.00	\$129.00
6 - 6.9	\$112.50	\$75.00	\$195.00	\$127.50	\$161.25
7 - 7.9	\$135.00	\$90.00	\$234.00	\$153.00	\$193.50
8 - 8.9	\$150.00	\$100.00	\$260.00	\$170.00	\$215.00
Corrections Officer Retirement Plan (CORP)					
not applicable	\$150.00	\$100.00	\$260.00	\$170.00	\$215.00
Public Safety Personnel Retirement System (PSPRS)					
not applicable	\$150.00	\$100.00	\$260.00	\$170.00	\$215.00

Note that there are new provisions regarding the provision of health insurance by the employer to survivors of police officers, corrections officers or probation officers killed in the line of duty. The new statute follows.

Legislation from the State of Arizona
House of Representatives
Forty-ninth Legislature
Second Regular Session
2010

CHAPTER 148

HOUSE BILL 2296

38-1103. Health insurance payments for spouse or dependents of law enforcement officer killed in the line of duty; definition

A. NOTWITHSTANDING ANY OTHER LAW, THE SURVIVING SPOUSE OF A DECEASED LAW ENFORCEMENT OFFICER IS ENTITLED TO RECEIVE PAYMENTS FOR HEALTH INSURANCE PREMIUMS FROM PUBLIC MONIES OF THE EMPLOYER OF THE LAW ENFORCEMENT OFFICER FOR THE FIRST YEAR AFTER THE DEATH OF THE LAW ENFORCEMENT OFFICER IF:

1. THE LAW ENFORCEMENT OFFICER WAS KILLED IN THE LINE OF DUTY OR DIED FROM INJURIES SUFFERED IN THE LINE OF DUTY.
2. THE LAW ENFORCEMENT OFFICER WAS ENROLLED IN THE EMPLOYER'S HEALTH INSURANCE PLAN AT THE TIME OF DEATH.
3. THE SURVIVING SPOUSE IS ENTITLED TO CONTINUE TO PARTICIPATE IN THE EMPLOYER'S HEALTH INSURANCE PLAN.

B. THIS SECTION APPLIES TO THE DEPENDENTS OF THE DECEASED LAW ENFORCEMENT OFFICER IF THE DEPENDENTS WERE ENROLLED IN THE EMPLOYER'S HEALTH INSURANCE PLAN AT THE TIME OF THE LAW ENFORCEMENT OFFICER'S DEATH.

C. PAYMENTS SHALL BE REDUCED FOR MONIES PAID FOR HEALTH INSURANCE PREMIUMS FOR THE SURVIVING SPOUSE OR DEPENDENTS OF THE SURVIVING SPOUSE FROM THE RETIREMENT PLAN FROM WHICH THE SURVIVING SPOUSE IS RECEIVING BENEFITS.

D. FOR THE PURPOSES OF THIS SECTION, "LAW ENFORCEMENT OFFICER" MEANS:

1. A PEACE OFFICER WHO IS CERTIFIED BY THE ARIZONA PEACE OFFICERS STANDARDS AND TRAINING BOARD.
2. A DETENTION OFFICER OR CORRECTIONS OFFICER WHO IS EMPLOYED BY THIS STATE OR A POLITICAL SUBDIVISION OF THIS STATE.

3. A PROBATION OFFICER OR SURVEILLANCE OFFICER WHO IS EMPLOYED BY THIS STATE OR A POLITICAL SUBDIVISION OF THIS STATE.

Sec. 3. Short title

This act may be cited as "Harrolle's Law".

Sec. 4. Retroactivity

This act is effective retroactively to from and after December 31, 2009.

Sec. 5. Emergency

This act is an emergency measure that is necessary to preserve the public peace, health or safety and is operative immediately as provided by law.

APPROVED BY THE GOVERNOR APRIL 26, 2010.

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 27, 2010.

**CORRECTIONS OFFICER RETIREMENT PLAN
DEATH BENEFICIARY CHECKLIST**

Forms and Documentation Required

- | | |
|--|--|
| Form C7D | Copy of Member's Death Certificate |
| Form 13 | Certified Personal Representative letter (if applicable) |
| Federal Tax Withholding Preference Certificate (Form W-4P) | Copy of Designated Beneficiary's Driver's License |
| State Tax Withholding Preference Certificate (Form A-4P) | Copy of Designated Beneficiary's Social Security Card |
| Form U3 Benefits Lump Sum Distribution Election | |
| Special Tax Notice (copy to Beneficiary) | |
| Minutes from Local Board Approving Death Benefit | |

IMPORTANT DEADLINE

To ensure sufficient time for processing for timely payment of benefits, all applications must be received by the Board of Trustee's Administrative Office by the 10th of the month in which the Designated Beneficiary will receive payment. Information should be double-checked for accuracy before submitting the application. Please note, a Local Board meeting must be conducted prior to the submission of the Death Beneficiary packet in order for our office to make payments effective in our system.

Form C7D- Application for a Death Benefit

Make sure this form is completely filled out, including the necessary signatures and verification of receipt by the employer. The applicant must check the appropriate description and provide the proof to confirm Personal Representative of Decedent's Estate if the applicant is not identified as the beneficiary on the Form 8, Beneficiary Designation.

If the member was active in the system, verification of final contributions from the local board is required before payment can be made to the beneficiary to CORP.

Form 13 - Authorization to Direct Deposit Benefit Payment

A beneficiary may request either a check or direct deposit for the lump sum payment if we are paying directly to the beneficiary. The direct deposit authorization must be received by the 10th of the month. If the beneficiary elects to rollover the monies to a qualified IRA account, then a check will be mailed to the address as indicated on the Form U3 Benefits page 2. Our office is currently in the process of setting up the option to direct deposit rollover monies. The Form U3 Benefits page 2 will be updated once this option is available.

Federal Tax Withholding Preference Certificate (Form W-4P)

With the enactment of the Tax Reform Act of 1986, PSPRS retirement benefits became taxable upon retirement except for a small percent monthly that is excludable as recapture of the retiree's after-tax contributions under rules established by the IRS.

The applicant has three options on this form with the exception noted below:

- Line 1 - No federal withholding will be deducted from the benefit check.
- Line 2 - Federal withholding based on the retiree's marital status and claimed allowances will be deducted from the benefit check.
- Line 3 - The amount of federal withholding will be the amount based on the retiree's marital status and claimed allowances plus the ADDITIONAL AMOUNT indicated on Line 3 over and above the amount calculated based on marital status and allowances. Applicants must select a marital status and fill in the number of allowances in order to

have an additional amount. Our office will not accept incomplete forms or forms that just have a flat dollar amount written in.

Note: Non-spouse applicants who do not rollover the taxable distribution will be required to have a mandatory twenty percent (20%) of federal taxes withheld at a minimum.

State Tax Withholding Preference Certificate (Form A-4P)

Legislative changes provide for state taxation of PSPRS retirement benefits in excess of \$2500 annually effective retroactive to tax year commencing January 1, 1989.

The applicant has 8 options on this form:

Line 1 – Check one option:

- An amount equal to zero point eight percent (0.8%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to one point three percent (1.3%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to one point eight percent (1.8%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to two point seven percent (2.7%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to three point six percent (3.6%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to four point two percent (4.2%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to five point one percent (5.1%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

Line 2 - No State Withholding will be deducted from the benefit check.

Applicants must select a percentage in order to have an additional amount withheld. Our office will not accept incomplete forms or forms that just have a flat dollar amount written in.

Form U3 – Benefits Lump Sum Distribution Election Form

If the beneficiary is a surviving spouse or an alternate payee (non-spouse) receiving a one-time lump sum death benefit payment, the beneficiary may choose to have the payment paid in a DIRECT ROLLOVER to a qualified “inherited” IRA or paid to them directly, or both. Thus, the beneficiary has the same the same choices as the deceased employee. See Special Tax Notice handout for more information. Beneficiaries are not generally subject to the additional 10% tax described in the Special Tax Notice handout, even if they are younger than age 59½.

Beneficiaries and Local Board staff are not authorized to sign in place of the Financial Institution Representative or have the rollover check mailed directly to them on Appendix A of the Form U3 Benefits.

Special Tax Notice

Provide a copy of the Special Tax Notice to the beneficiary.

Local Board Minutes Approving the Designated Beneficiary

The Local Board must forward the minutes or letter verifying a Designated Beneficiary's eligibility and approval for payment to CORP as prescribed in A.R.S. Section 38-893.M.

A.R.S. Section 38-893.G, provides “No later than twenty days after taking action, the local board shall submit to the board of trustees the minutes from the local board meeting that include the name of the member affected by its decision, a description of the action taken and an explanation of the reasons and documents supporting the local board's action.

**CORRECTIONS OFFICER RETIREMENT PLAN
DISABILITY RETIREMENT CHECKLIST**

Forms and Documentation Required

- | | |
|--|---|
| Form C5-EE | Copy of Member's Birth Certificate |
| Form C5-LB | If Married: |
| Form C5-LB-A, T, or O (as applicable) | Copy of Spouse's Birth Certificate |
| Form C8 (Optional) | Copy of Marriage Certificate |
| Form C11D | If Eligible Children: |
| Form C12 | Copy of Children's Birth Certificates |
| Form 13 | Medical Documentation for Disabled Children (If applicable) |
| Federal Tax Withholding Preference Certificate
(Form W-4P) | If Divorced during period of employment: |
| State Tax Withholding Preference Certificate
(Form A-4P) | Photocopy of complete Divorce Decree, or |
| Minutes from Local Board Approving Retirement | Certified copy of Plan-approved Domestic Relations Order |
| Medical Reports and Documentation Supporting Award of
Disability Retirement | |

IMPORTANT DEADLINE

To ensure sufficient time for processing for timely payment of retirement benefits, all applications must be received by the Board of Trustee's Administrative Office by the 10th of the month in which the retiree will receive their first benefit payment. For example, if a retiree's last day of work is in July, their retirement becomes effective August 1st and their retirement application should be submitted to the board of trustees no later than August 10th. Information should be double checked for accuracy before submitting the application. Please note, a Local Board meeting must be conducted prior to the submission of the Disability Retirement packet in order for our office to make payments effective in our system.

Form C5-EE - Application for Disability Retirement

Make sure that the applicant has completely filled out the application (pages 1 & 2) and a local board representative must sign on page 2 verifying the application is completed. The bottom of page 2 requires an acknowledgement of "received stamp or signature of local board representative and date" be filled in.

The Date of Disability should be the date of the member's injury or the date the member's physical or mental condition was first diagnosed as to preclude him from further employment with the CORP employer.

By definition, "accidental disability" means a physical or mental condition that the local board finds totally and permanently prevents an employee from performing a reasonable range of duties within the employee's department, was incurred in the performance of the employee's duties and was the result of either physical contact with inmates, responding to a confrontational situation with inmates or a job-related motor vehicle accident.

By definition, "total and permanent disability" means a physical or mental condition which the local board finds totally and permanently prevents a member from engaging in any gainful employment and which is the direct and proximate result of the member's performance of their duty as an employee of an employer.

By definition, "ordinary disability" means a physical condition that the local board determines will prevent an employee from totally and permanently performing a reasonable range of duties within the employee's department or a mental condition that the local board determines will prevent an employee from totally and permanently engaging in any substantial gainful activity.

The applicant should provide a brief description of the Nature and Cause of the Disability as well as a listing of all doctors and hospitals which have treated him for the disability and three years prior. The applicant should be encouraged to provide as much medical information as is appropriate to assist the Local Board in making its determination. The Authorizations on the top of page 2 should give the Local Board and its designated physician access to the applicant's

complete medical history when necessary. It also gives the Local Board and Board of Trustees access to all information related to leave(s) of absence without pay and/or application(s) for and/or receipt of Worker's Compensation Benefits. The applicant must also confirm that they understand that the Board of Trustees may perform a review of the disability application to ensure that the applicant and Local Board are in compliance with statutory requirements.

Form C5-LB – Local Board Determination For Disability Retirement

The Local Board will need to print and complete the disability questionnaire that is selected on the C5-EE, Application for Disability Application. The questionnaire will also need to be completed by the Independent Medical Examination (IME) physician, if the Local Board appoints a medical board.

The first section of the C5-LB is requires the local board to verify service dates, termination date if applicable, and the current work status of the applicant.

The second section requires the Local Board Chairman or Secretary to complete indicating the action taken by the Local Board. Please note: "Payment of an accidental disability pension, a total and permanent disability pension, or an ordinary disability pension commences on the first day of the calendar month next following the member's date of retirement." (38-890(A))

The Local Board must then forward to the Board of Trustees' office, the original C5-EE and required documents, C5-LB, Disability Questionnaire, a copy of the IME, and the Local Board meeting minutes sent via certified mail pursuant to A.R.S. 38-893.G.

Form C5-LB-A, C5-LB-T, or C5-LB-O Disability Questionnaires

The applicable Disability Questionnaire must be completed by both the Local Board and the Medical Board as appointed by the Local Board.

Form 8 - Beneficiary Designation Form (Optional)

Retirement is a critical time for members to update their beneficiary information. Many members are surprised to find who we have listed as their beneficiaries (ex-spouses, deceased parents, etc.), so we would encourage retirees to submit this form along with their retirement applications to ensure that all benefit payments are made to the correct person(s)

Form C11D - Benefit Calculations

Be sure to verify the final contribution amount to CORP.

Credited Service: In calculating the length of the member's credited service, make sure that you use the statutory definition of "Credited Service" in A.R.S. Section 38-881.11:

“...credited service transferred to the retirement plan from another retirement system or plan for public employees of this state, plus service as a member of the retirement plan for which member contributions are on deposit in the fund.”

By definition, a "leave without pay" is not "credited service as a member of the retirement plan for which member contributions are on deposit in the fund" and therefore cannot be considered as credited service for purposes of computing a member's retirement benefit on this form. The "period" to be considered is a FULL pay period. Do not record individual days or hours as leave without pay. Any FULL pay period(s) where the member did not receive compensation and CORP did not receive contributions must be noted on the Form C5 and should be subtracted from the member's total service to come up with the length of credited service.

Average monthly salary: In calculating a retiree's average monthly salary, the current CORP statute allows the member to use a period of thirty-six (36) consecutive months of credited service in which the member received the highest salary within the last one hundred twenty (120) months of service. Average monthly salary means the aggregate amount of salary that is paid a member divided by the member's months of credited service if the member has less than thirty-six months of credited service.

For calculating the benefit for an Accidental, Total and Permanent Disability, and Ordinary Disability, the current CORP statute allows the member to use "thirty-six consecutive months of service in which the member received the highest salary within the last one hundred twenty months of service". (A.R.S. Section 38-881.7)

These 36 months do not have to be calendar years. Also if these 3 considered years include periods of non-paid or partially paid industrial leave, you should include "the salary the employee would have received in this job classification if the employee was not on industrial leave". Be careful in determining the 36 consecutive months of salary. If the member's last day of work was June 26, 2010, the beginning of the 36 month period ending on that date would be June 27, 2007, not June 26, 2007.

If benefit calculations are incorrect when submitted, a corrected Form C11D and a new Form C12 with the member's signature must be submitted before the first benefit check can be released to the retiree.

Form C12 - Notification of Benefits and Election

Make sure that you mark the type of benefit: Accidental Disability Retirement, Total and Permanent Disability Retirement, or Ordinary Disability.

The "Date First Payment Due" should be the last day of the next calendar month following the retiree's last day of employment. For example, if the retiree's last day of work is on December 23, 1989, the "Date First Payment Due" should be January 31, 1990 (last business day of the month).

Make sure the member initials the appropriate election line on the bottom section of the form and then signs the Election and Acceptance in the presence of a witness.

Form 13 - Authorization to Direct Deposit Benefit Payment

A retiree's first monthly benefit can be issued either in check form or by direct deposit, if the direct deposit authorization is received by the 10th of the month. The Direct Deposit option enables us to electronically transfer monthly benefits into a retiree's bank or credit union account. The check will be mailed to the retiree's address indicated on Form C5. The retiree may view the direct deposit notice on the Members Only section of our website at www.psprs.com.

Have the retiree complete Form 13 and attach a voided check for the bank or credit union account into which the benefits are to be deposited. This office relies on the retiree to provide correct routing and account information for the direct deposit and any incorrect information will result in a delay in the direct deposit.

Federal Tax Withholding Preference Certificate (Form W-4P)

As a general rule, the job-related disability pensions available under the CORP are tax-exempt at the federal level for disability retirees who retire with less than twenty years of credited service. However, disability retirees with more than twenty years of service and ordinary disability retirees will be taxed on their retirement benefits at the federal level.

With the enactment of the Tax Reform Act of 1986, CORP retirement benefits became taxable upon retirement except for a small percent monthly that is excludable as recapture of the retiree's after-tax contributions under rules established by the IRS.

REGARDLESS OF WHETHER THE BENEFIT IS TAXABLE, ALL RETIREES MUST COMPLETE A W-4P.

The retiree has three options on this form:

Line 1 - No federal withholding will be deducted from the benefit check.

Line 2 - Federal withholding based on the retiree's marital status and claimed allowances will be deducted from the benefit check.

Line 3 - The amount of federal withholding will be the amount based on the retiree's marital status and claimed allowances plus the ADDITIONAL AMOUNT indicated on Line 3 over and above the amount calculated based on marital status and allowances. Retiree's must select a marital status and fill in the number of allowances in order to have an additional amount. Our office will not accept incomplete forms or forms that just have a flat dollar amount written in.

State Tax Withholding Preference Certificate (Form A-4P)

Legislative changes provide for state taxation of PSPRS retirement benefits in excess of \$2500 annually effective retroactive to tax year commencing January 1, 1989.

The retiree has 8 options on this form:

Line 1 – Check one option:

- An amount equal to zero point eight percent (0.8%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to one point three percent (1.3%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to one point eight percent (1.8%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to two point seven percent (2.7%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to three point six percent (3.6%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to four point two percent (4.2%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.
- An amount equal to five point one percent (5.1%) of the member's taxable amount of distribution in Box 2a of the federal Form 1099-R will be deducted from the benefit check.

Line 2 - No State Withholding will be deducted from the benefit check.

Retirees must select a percentage in order to have an additional amount withheld. Our office will not accept incomplete forms or forms that just have a flat dollar amount written in.

Local Board Minutes Approving Retirement

The Local Board's initial authorization to the Board of Trustee's Administrative Office to pay retirement benefits is on Form C12 - Notification of Benefits and Election wherein the Local Board Chairman certifies that the Local Board "has met and determined that the applicant...is eligible for the benefit payment as shown above." This gives us the authority to issue the retiree's initial retirement benefit.

A.R.S. Section 38-893.G, provides "No later than twenty days after taking action, the local board shall submit to the board of trustees the minutes from the local board meeting that include the name of the member affected by its decision, a description of the action taken and an explanation of the reasons and documents supporting the local board's action.

In addition, A.R.S. Section 38-893.M., provides "The secretary of the local board shall keep a record and prepare minutes of all meetings in compliance with Chapter 3, Article 3.1 of this title and forward the minutes to the Board of trustees as prescribed by Subsection G of this section.

The minutes of the Local Board meeting at which a disability determination is made should include a concise statement of the medical evidence upon which the Local Board based its findings, identified simply by document dates and author. If a conflict exists in the medical evidence presented to the Local Board, the minutes should contain a brief statement as to how the Local Board resolved the conflict. A copy of the minutes of the Local Board meeting at which a retiree's disability retirement benefit was approved must be placed in the retiree's file to complete the application process.

Health Insurance Plans and Subsidy Available to Retirees

Retiring Corrections Officer Retirement Plan (CORP) members and their eligible dependents may be eligible to enroll in one of the two State of Arizona retiree group health insurance programs which offer Medical and Dental coverage. The retiring member may also have an option to continue the coverage with their employer. The prospective retiree would need to contact their employer insurance liaison to find out if they are eligible.

The two State programs are:

1. The Benefits Options plan, this plan is administered by the Arizona Department of Administration (ADOA) and is available to any retiring members **whose employer is the state of Arizona**. Please note that ADOA only offers their coverage at the time of retirement and will not allow anyone who declines their coverage to join at a later date. A survivor is only eligible to take the ADOA coverage if the member was qualified for retirement before death or already receiving a monthly benefit and she is on the plan with the member at time of death.

2. The Arizona State Retirement System (ASRS) plan, this plan is administered by Arizona State Retirement System and is available to all CORP retirees. Enrollment is handled by the PSPRS office for their retirees. The ASRS plans are offered to survivors regardless of whether on the plan before death of member or not. Retirees may join this plan during any open enrollment period or qualified life event.

Information packets regarding available insurance coverage under these plans can be obtained by contacting the offices shown below:

The Department of Administration
Benefits Office
100 N. 15th Ave. #103
Phoenix, AZ 85007
Phone numbers:
(602)-542-5008
(800)-304-3687
Website: www.hr.state.az.us/benefits

Public Safety Personnel Retirement System
3010 E Camelback Rd., Suite 200
Phoenix, AZ 85016
Phone Number:
(602)-255-5575
Fax Number:
(602)-296-2370
Website: www.psprs.com

Health Insurance Premium Benefit (Subsidy)

State statute provides a subsidy from PSRPRS to retired members and survivors receiving a monthly retirement pension and who are enrolled in a qualified retiree health insurance programs from their employer or the state. The following table is a breakdown of the amounts available.

	Members Only		Member & Dependents		
	NOT MEDICARE ELIGIBLE	MEDICARE ELIGIBLE	ALL NOT MEDICARE ELIGIBLE	ALL MED. ELIGIBLE	ONE WITH MEDICARE
Elected Officials' Retirement Plan (EORP)					
5 – 5.9	\$90.00	\$60.00	\$156.00	\$102.00	\$129.00
6 – 6.9	\$112.50	\$75.00	\$195.00	\$127.50	\$161.25
7 – 7.9	\$135.00	\$90.00	\$234.00	\$153.00	\$193.50
8 – 8.9	\$150.00	\$100.00	\$260.00	\$170.00	\$215.00
Corrections Officer Retirement Plan (CORP)					
not applicable	\$150.00	\$100.00	\$260.00	\$170.00	\$215.00
Public Safety Personnel Retirement System (PSPRS)					
not applicable	\$150.00	\$100.00	\$260.00	\$170.00	\$215.00

Note that there are new provisions regarding the provision of health insurance by the employer to survivors of police officers, corrections officers or probation officers killed in the line of duty. The new statute follows.

Legislation from the State of Arizona
House of Representatives
Forty-ninth Legislature
Second Regular Session
2010

CHAPTER 148

HOUSE BILL 2296

38-1103. Health insurance payments for spouse or dependents of law enforcement officer killed in the line of duty: definition

A. NOTWITHSTANDING ANY OTHER LAW, THE SURVIVING SPOUSE OF A DECEASED LAW ENFORCEMENT OFFICER IS ENTITLED TO RECEIVE PAYMENTS FOR HEALTH INSURANCE PREMIUMS FROM PUBLIC MONIES OF THE EMPLOYER OF THE LAW ENFORCEMENT OFFICER FOR THE FIRST YEAR AFTER THE DEATH OF THE LAW ENFORCEMENT OFFICER IF:

1. THE LAW ENFORCEMENT OFFICER WAS KILLED IN THE LINE OF DUTY OR DIED FROM INJURIES SUFFERED IN THE LINE OF DUTY.
2. THE LAW ENFORCEMENT OFFICER WAS ENROLLED IN THE EMPLOYER'S HEALTH INSURANCE PLAN AT THE TIME OF DEATH.
3. THE SURVIVING SPOUSE IS ENTITLED TO CONTINUE TO PARTICIPATE IN THE EMPLOYER'S HEALTH INSURANCE PLAN.

B. THIS SECTION APPLIES TO THE DEPENDENTS OF THE DECEASED LAW ENFORCEMENT OFFICER IF THE DEPENDENTS WERE ENROLLED IN THE EMPLOYER'S HEALTH INSURANCE PLAN AT THE TIME OF THE LAW ENFORCEMENT OFFICER'S DEATH.

C. PAYMENTS SHALL BE REDUCED FOR MONIES PAID FOR HEALTH INSURANCE PREMIUMS FOR THE SURVIVING SPOUSE OR DEPENDENTS OF THE SURVIVING SPOUSE FROM THE RETIREMENT PLAN FROM WHICH THE SURVIVING SPOUSE IS RECEIVING BENEFITS.

D. FOR THE PURPOSES OF THIS SECTION, "LAW ENFORCEMENT OFFICER" MEANS:

1. A PEACE OFFICER WHO IS CERTIFIED BY THE ARIZONA PEACE OFFICERS STANDARDS AND TRAINING BOARD.
2. A DETENTION OFFICER OR CORRECTIONS OFFICER WHO IS EMPLOYED BY THIS STATE OR A POLITICAL SUBDIVISION OF THIS STATE.
3. A PROBATION OFFICER OR SURVEILLANCE OFFICER WHO IS EMPLOYED BY THIS STATE OR A POLITICAL SUBDIVISION OF THIS STATE.

Sec. 3. Short title

This act may be cited as "Harrolle's Law".

Sec. 4. Retroactivity

This act is effective retroactively to from and after December 31, 2009.

Sec. 5. Emergency

This act is an emergency measure that is necessary to preserve the public peace, health or safety and is operative immediately as provided by law.

APPROVED BY THE GOVERNOR APRIL 26, 2010.

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 27, 2010.

CORRECTIONS OFFICER RETIREMENT PLAN

DISABILITY PROCEDURE

1. The applicant files Application for Disability (Form C5-EE) with the Local Board.
2. The Local Board sets meeting to determine whether the applicant either filed the application after the disabling incident or has applied for a disability retirement within one year after the date the member ceases to be an employee. For Ordinary disability dispatcher applicants, the date of disability must have occurred on or after 9/21/2006 and for all other CORP members the date of disability must have occurred on or after 9/26/2008.
3. If medical evidence and application warrants appointment of an independent medical evaluation (IME), then the Local Board appoints a Medical Board to perform an IME of the applicant.
4. The Local Board forwards a copy of the claimant's C5-EE, Application for Disability, which includes a medical release authorization for prior treatment records, and a copy of the applicant's medical records to the appointed medical board.

For an Accidental Disability Application, the Local Board must direct the medical board to complete Form C5-LB-A, Accidental Disability Questionnaire. In addition to the completion of Form C5-LB-A, the Local Board should request the medical board to prepare a written report that specifically addresses the following statutory requirements in its report:

- a. Does the claimant have a physical or mental condition which totally and permanently prevents him from performing a reasonable range of duties within their department?
- b. Does the claimant's disability result from a physical or mental condition or injury that existed or occurred before the claimant's date of membership in the CORP?
- c. Was the disabling condition or injury incurred in the performance of the employee's duties and was it the result of any of the following:
 - i. physical contact with inmates, prisoners, parolees or persons on probation.
 - ii. responding to a confrontational situation with inmates, prisoners, parolees or persons on probation.
 - iii. a job-related motor vehicle accident while on official business for the claimant's employer. Note that a job-related motor vehicle accident does not include an accident that occurs to or from work, nor does it include the situation where the claimant is found guilty of violating a personnel rule, a rule established by the employer or a state or federal law in connection with the job-related motor vehicle accident.

Any departmental accident reports or documentation of an on-the-job injury should be provided to the medical board. Although you should ask your medical board to answer this question, the Local Board may be in a better position to answer this question through examination of the departmental reports or documentation as well as direct testimony from persons familiar with the incident.

For a Total and Permanent Disability Application:

The Local Board must direct the medical board to complete Form C5-LB-T, Total and Permanent Disability Application Questionnaire. In addition to the completion of Form C5-LB-T, the Local Board should request the medical board to prepare a written report that specifically addresses the following statutory requirements in its report:

- a. Does the claimant have a physical or mental condition which totally and permanently prevents him from engaging in any gainful employment? In this context, the term "gainful employment" means the capability of performing a moderate amount of work with reasonable regularity without restriction to the type of work performed before the impairment. See *Cleland v. CORP* 818 P.2d 237; 169 Ariz 252 (Ariz. App. 1991) and the enclosed memorandum on this subject.

- b. Does the claimant's disability result from a physical or mental condition or injury that existed or occurred before the claimant's date of membership in the CORP?
- c. Was the disabling condition or injury incurred as a direct and proximate result of the member's performance of their duty as an employee of the employer? Any departmental accident reports or documentation of an on-the-job injury should be provided to the medical board.

For an Ordinary Disability Application:

The Local Board must direct the medical board to complete Form C5-LB-O, Ordinary Disability Questionnaire. In addition to the completion of Form C5-LB-O, the Local Board should request the medical board to prepare a written report that specifically addresses the following statutory requirements in its report:

- a. Does the claimant have a physical condition which totally and permanently prevents him from performing a reasonable range of duties within the employee's department or a mental condition that totally and permanently prevents him from engaging in any substantial gainful activity? In this context, the term "gainful employment" means the capability of performing a moderate amount of work with reasonable regularity without restriction to the type of work performed before the impairment. See *Cleland v. CORP* 818 P.2d 237; 169 Ariz 252 (Ariz. App. 1991) and the enclosed memorandum on this subject.
 - b. Does the claimant's disability result from a physical or mental condition or injury that existed or occurred before the claimant's date of membership in the CORP?
5. After receipt of the medical board's medical evaluation, the Local Board sets a meeting to consider the claimant's application and the medical board's report. The Local Board will need to make a determination on each of the issues presented to the medical board. Any motion to approve or disapprove a claimant's application for disability should include a reference to the medical board evaluation upon which the determination was based. A Local Board can consider any medical evidence that the claimant may want to provide; however, the statutes are clear that an award of an accidental disability or total and permanent disability shall be based upon the appointed Medical Board's evaluation. Material conflicts in medical evidence shall be resolved by the findings of the Local Board. Disability determinations by the State Comp Fund or other workers' compensation bodies are not binding on the Local Board.
 6. Once an application for disability is approved, the Local Board Chairman or Secretary completes the determination section on the Form C5-LB and forwards it to the Board of Trustees' Administrative Office together with completed Forms C5-EE, C5-LB-A, T, or O Disability Questionnaire, C11, C12, Form 13, A-4P, W-4P, Form C8 (optional) and supporting documentation (birth certificates, marriage certificates, etc.), along with a copy of the Local Board meeting minutes approving the retirement. The Local Board must also forward to the copies of all medical evidence including the Independent Medical Evaluation considered by the Local Board in reaching its decision. If conflicts in medical evidence were resolved by the Local Board, the Minutes forwarded to the Board of Trustees must explain how such conflicts were resolved.
 7. The Claimant or the Board of Trustees may request a Rehearing on the Local Board's decision pursuant to statutory provisions.
 8. Payment of an accidental, total and permanent, or an ordinary disability pension shall commence as of the first day of the month following the member's date of retirement. The effective date of an accidental, total and permanent, or an ordinary disability retirement shall not predate the date of disability or the date the member ceases to be an employee. Termination of payment of the accidental, total and permanent, or ordinary disability pension occurs at the end of the calendar month in which the event causing the termination occurred. The payment shall be made for the full month of termination. The monthly accidental and total and permanent disability pension amount is equal to fifty per cent of the member's average monthly salary. Except for a full-time dispatcher, the amount of an ordinary disability pension is equal to a fraction times the member's normal retirement pension that is computed as if the member had twenty years of credited service. The fraction is the result obtained by dividing the member's actual years of credited service, not to exceed twenty years of credited service, by twenty. For a full-time dispatcher, the amount of an ordinary disability pension is equal to a fraction times the member's normal retirement pension that is computed as if the member had twenty-five years of credited service. The fraction is the result obtained by dividing the member's actual years of credited service, not to exceed twenty-five years of credited service, by twenty-five.

9. An accidental, total and permanent, or an ordinary disability pension is terminated if the Local Board finds the retired member no longer meets the requirements for disability retirement. During the period between the effective date of an accidental, total and permanent, or an ordinary disability retirement and the date the disabled retired member attains age sixty-two, the Local Board may require an accidental, total and permanent, or an ordinary disability retired member to undergo periodic re-evaluation of the continuation of disability benefits. If the member refuses to submit to re-evaluation, the Local Board may suspend payment of the pension. If the refusal continues for one year, the Local Board may revoke the accidental, total and permanent, or ordinary disability retired member's right to the pension.

TOTAL AND PERMANENT DISABILITY MEMORANDUM

TO: All Corrections Officer Retirement Plan Members
FROM: The
DATE: February 15, 2007
RE: Total and Permanent Disability under the Corrections Officer Retirement Plan

Among other things, a member qualifies for disability benefits if he can demonstrate that his physical or mental condition (1) totally and permanently prevents him "from engaging in any gainful employment" and (2) is the direct and proximate result of his job duties. See A.R.S. § 38-881 (36). The term "any gainful employment" means the capability of performing a moderate amount of work with reasonable regularity, or more specifically, at least four (4) hours of work (4) four days a week for which the claimant earns at least \$300 monthly and/or the minimum hourly wage. "Gainful employment" is not restricted to the type of work performed before impairment, nor is it limited to job opportunities actually available and/or located near the claimant's home.

**CORRECTIONS OFFICER RETIREMENT PLAN
DUE PROCESS GUIDELINES FOR DISABILITY REHEARINGS**

The interest of an applicant in obtaining a disability benefit, if he meets the qualifications, has generally been held to be a property interest entitled to due process protections, including some form of hearing right.

A.R.S. Section 38-893 provides, in part, as follows:

G. An action by a majority vote of the members of a local board that is not inconsistent with the provisions of the plan is final, conclusive and binding on all persons affected by it, unless a timely application for a rehearing or appeal is filed as provided in this article. No later than 20 days after taking action, the local board shall submit to the board of trustees the minutes from the local board meeting that include the name of the member affected by its decision, a description of the action taken and an explanation of the reasons and documents supporting the local board's action. The board of trustees may not implement and comply with any local board action that does not comply with the internal revenue code or that threatens to jeopardize the plan's status as a qualified plan under the internal revenue code.

H. A claimant or the board of trustees may apply for a rehearing before the local board within the time period prescribed in this subsection, except that if a decision of a local board violates the internal revenue code or threatens to jeopardize the plan's status as a qualified plan under the internal revenue code, no limitation period for the board of trustees to seek a rehearing of a local board decision applies. A claimant or the board of trustees shall file an application for rehearing in writing with a member of the local board or its secretary within sixty days after:

1. The claimant receives notification of the local board's original action by certified mail, by attending the meeting at which the action is taken or by receiving benefits from the plan pursuant to the local board's original action, whichever occurs first.

2. The board of trustees receives notification of the local board's original action as prescribed by subsection G of this section.

I. A hearing before a local board on a matter remanded from the superior court is not subject to rehearing before the local board.

J. Decisions of local boards are subject to judicial review pursuant to Title 12, Chapter 7, Article 6.

The important aspect of the above-referenced statutes are: first, the requirement of proper notice to the board of trustees of the local board's original action; and second, the time period set for applying for a rehearing. The Arizona courts have construed these requirements quite literally.

The basic requirements for an adequate rehearing process are as follows:

1. NOTICE OF OPPORTUNITY FOR REHEARING

A. Notice of Local Board's Original Action on the Application with notification to the applicant of their statutory right to apply for a rehearing within the time period prescribed above. The CORP statute requires this notice to be by certified mail or the applicant's attendance at the Local Board meeting at which the action takes place.

B. Notice to Applicant of Scheduled Rehearing. This notice requirement for a rehearing is intended to ensure that the applicant is made fully aware of the time, place and subject matter of the rehearing so as to have a reasonable opportunity to prepare their case. This second notice should also be by certified mail.

2. TRANSCRIPTION OF REHEARING

Because of the likelihood of an adverse decision by the Local Board being challenged through the court system, all rehearings should at least be tape recorded, if not transcribed, to preserve the record for possible appeal. If there is no adequate record preserved of the rehearing, the Arizona courts have tended to grant a trial de novo (a new trial) at the Superior Court level to determine the applicant's eligibility for the disability. With an adequate record of the rehearing proceedings, an applicant can only challenge the Local Board's determination as "arbitrary and capricious"--a difficult legal standard to prove. With a trial de novo, the issue of the applicant's eligibility for the disability is reopened to a trial by a

judge or jury--a much more expensive proposition for the Local Board. The money spent on transcribing or recording the rehearing can be saved many times over in the event of an appeal to the Superior Court.

3. AN IMPARTIAL DECISION-MAKER

Due process requires that Local Board members make their decision on the basis of the medical evidence before them, not on the basis of personal prejudices and information obtained outside the scope of the rehearing. Extraneous personnel information should not be considered in determining the applicant's eligibility for a disability retirement. Any Local Board member should disqualify himself from the determination if he feels there is any type of conflict of interest.

4. THE RIGHT TO PRESENT EVIDENCE AND ARGUMENT ORALLY

The fact that due process requires that the applicant be allowed a rehearing does not necessarily require a full-scale adversarial quasi-judicial hearing. It may be enough that the applicant has the opportunity to appear before the Local Board to present to it reasons why he is entitled to the disability retirement. The burden of proof for establishing the disability rests with the applicant.

The CORP statute requires that Local Boards shall base "a finding of total and permanent disability, accidental disability, and ordinary disability on medical evidence obtained by a medical doctor or clinic selected by the local board." (A.R.S. Section 38-886.F) Therefore, although the Local Board can hear medical evidence from doctors other than the doctor appointed by the Local Board, they must base their determination on their designated doctor's report.

For an accidental or total and permanent disability application, the Local Board will be called on to make the determination of whether or not the disability is service-related. The Local Board can rely on lay information to make this determination if the designated doctor does not adequately address the issue.

In a case where the Local Board determines that their designated doctor or clinic may not have had access to new medical evidence provided at the rehearing by the applicant that may alter the designated doctor's opinion regarding the application, the Local Board can determine that the case is a "special case" and refer the new medical information for reevaluation by the Local Board's designated doctor or refer the applicant to a new doctor designated by the Local Board pursuant to A.R.S. Section 38-893.D.6.

Disability hearings and rehearing are subject to Arizona's open meeting laws. However, the local boards should review and discuss a member's confidential medical records in executive session only. However, a final decision on a member's entitlement to benefits must be made in an open public meeting. See Fund Manager's Opinion 1998-2. To allow a member to present their case to the local board in an orderly manner and to prevent the necessity of having to go into executive session numerous times, the member may wish to waive the confidentiality requirements. This waiver is included in the disability application.

5. THE RIGHT TO BE ACCOMPANIED BY COUNSEL

If the applicant chooses to be represented by an attorney at a rehearing, the Local Board should explain to the attorney the nature and procedure of the rehearing so the attorney will know what to expect and how to prepare their case.

6. THE RIGHT TO HAVE THE DETERMINATION BE BASED SOLELY UPON EVIDENCE ADDUCED AT THE REHEARING.

All evidence being considered should be adequately identified during the rehearing--documents by date, title and author, as well as oral testimony. Any evidence not specifically documented in the transcript or record of the rehearing should not be considered in the Local Board's determination.

7. A STATEMENT BY THE LOCAL BOARD OF THE REASONS FOR THEIR DECISION AND THE REHEARING EVIDENCE RELIED UPON FOR THAT PURPOSE.

After the determination at the rehearing, the Local Board should again give formal written notice by certified mail to the applicant detailing the Local Board's decision and the evidence relied upon by the Local Board in reaching their decision. The minutes of the rehearing should also include specific findings of the Local Board supporting their decision with a thorough explanation of how the Local Board resolved any conflicts in the medical evidence.

CORRECTIONS OFFICER RETIREMENT PLAN

A GUIDE TO PROCESSING AN ACCIDENTAL, TOTAL AND PERMANENT, OR AN ORDINARY DISABILITY RETIREMENT

The following letters and procedures are intended to be a guide in processing an accidental, total and permanent, or an ordinary disability retirement under the Corrections Officer Retirement Plan.

You are free to use or modify these letters and procedures as you wish. They are not intended to supersede any current letters or procedures that you, as the Local Board, may have already implemented.

STEP I

July 1, 2011

Re: Disability Application – Corrections Officer Retirement Plan

Dear Mr. Smith:

Per your request of this date, I am enclosing an Application for Disability Retirement (Form C5-EE) and the applicable Corrections Officer Retirement Plan statutes pertaining to disability benefits available under the System. Please review the highlighted areas of the statutes provided and if you feel that you are eligible to apply for a disability pension, complete and return the application to my attention at the address above. Please be sure that you indicate on the form the type of disability for which you are applying.

Please be advised that the local board can review and discuss your confidential records only in executive session. However, a final decision on your entitlement to a disability benefit will be made in an open public meeting. To allow you to present your case to the local board in an orderly manner and to prevent the necessity of having to go into executive session numerous times, please complete the waiver of confidentiality on page 2 of Form C5-EE, Application for Disability Retirement.

If you have any further questions regarding the above, do not hesitate to contact me.

Sincerely,

Local Board Secretary

Enclosures

STEP II

July 6, 2011

Re: Application for Disability Retirement - Corrections Officer Retirement Plan

Dear Mr. Smith:

The Corrections Officer Retirement Plan Local Board for xxxx has received your Application for Disability Retirement dated July 5, 2011. We have recently requested copies of your medical files from the treating physicians that you listed on your application.

Pursuant to the statutes governing disability applications under the CORP, Section 38-886, the Local Board requests that you be examined by Dr. Young, a specialist in occupational medicine, in order to provide the Local Board with an independent medical evaluation of your present condition. We have notified Dr. Young of our request and you will need to contact Dr. Young's office at your earliest convenience to set up an appointment for his examination. Costs of this examination will be billed directly to this office.

Dr. Young's office address and telephone number are as follows:

Dr. Young, M.D.
123 East Cortez
Phoenix, Arizona 85008
(602) 296-9229

If you have any questions regarding this matter, do not hesitate to contact me.

Sincerely,

Local Board Secretary

Enclosure

STEP III

July 9, 2011

Dr. Jones, M.D.
Southwest Disabilities
650 Apuwai Place
Tucson, Arizona

Re: Smith - Application for Disability Retirement - Corrections Officer Retirement Plan

Dear Doctor Jones:

Pursuant to the attached Medical Authorization, request is hereby made for copies of any and all information, records, reports and x-rays regarding your past medical treatment of the above-named patient. This person has applied for a medical disability retirement under our retirement program and, by statute, the Local Board is required to base its determination of eligibility on medical information from a physician appointed by the Local Board. In this case, the Local Board has appointed the following doctor to examine the applicant:

Dr. Young, M.D.
123 Cortez
Phoenix, Arizona 85008

Please forward the requested medical information at your earliest convenience directly to my attention at 500 East Chandler, Phoenix, Arizona 85014. Please bill any costs associated with making copies of the requested medical information directly to this office.

Sincerely,

Local Board Secretary

Enclosure

STEP IV

July 25, 2011

Dr. Young, M.D.
123 Cortez
Phoenix, Az. 85008

Re: Mr. Smith - Disability Application – Corrections Officer Retirement Plan

Dear Doctor Young:

I represent the County of xxxx Corrections Officer Retirement Plan Local Board, a retirement system for state correctional officers.

Mr. Smith, a _____ for the county of xxxx, has recently applied for a medical disability retirement under the Corrections Officer Retirement Plan A.R.S. 38-886. On behalf of the Local Board, I hereby request that you conduct a medical evaluation of Mr. Smith in order to determine his eligibility for such a medical disability. Please bill all costs of the evaluation directly to this office at the above address.

I am enclosing a copy of Mr. Smith's Application for Disability Retirement dated July 5, 2011. I will request copies of all prior medical information, records, reports and x-rays relating to Mr. Smith's physical or mental condition and treatment from the physicians he has listed on his disability application and forward this information to you as soon as I receive it.

I am also enclosing a copy of the pertinent statutes relating to Mr. Smith's eligibility for a disability retirement and request that you complete the attached Disability Questionnaire and prepare a written report that specifically addresses the following statutory requirements:

(NOTE: What follows are the statutory requirements for an accidental disability. If applying for a total and permanent or an ordinary disability make sure you prescribe the statutory requirements for that type of disability.)

1. Does Mr. Smith have a physical or mental condition which totally and permanently prevents him from performing a reasonable range of duties within the employee's department. For your information I am enclosing a copy of the duties which are required of a _____ for the county of xxxx.
2. Do you feel that Mr. Smith's disabling condition or injury was incurred in the performance of Mr. Smith's duty as a _____?
3. Does Mr. Smith's disability result from a physical condition or injury that existed or occurred before the claimant's date of membership in the CORP? For your information, Mr. Smith began employment with the city as a full-time _____ on August 1, 1988.

Tony Young, M.D.
July 25, 2011
Page -2-

4. Was Mr. Smith's disability a result of any of the following:
- (a) Physical contact with inmates, prisoners, parolees or persons on probation
 - (b) Responding to a confrontational situation with inmates, prisoners, parolees or persons on probation
 - (c) A job related motor vehicle accident while on official business for the employee's employer. A job related motor vehicle accident does not include an accident that occurs on the way to or from work. Persons found guilty of violating a personnel rule, a rule established by the employee's employer or a state or federal law in connection with a job related motor vehicle accident do not meet the conditions for accidental disability.

In your written evaluation of Mr. Smith's condition, feel free to give a narrative of Mr. Smith's past medical history, the incidents leading to his injury for which he seeks medical retirement, and his current medical condition. The Local Board is required by law to base its decision on whether or not to grant Mr. Smith a medical retirement based on medical evidence by a doctor appointed by the Local Board. For this reason, it is imperative that you answer the questions posed above and complete and return the enclosed Disability Questionnaire.

I am simultaneously mailing a letter to Mr. Smith instructing him to contact your office at his earliest convenience to set up an appointment to be examined by you.

If you have any questions regarding this matter, do not hesitate to contact me.

Sincerely,

Local Board Secretary

Enclosures

STEP V

August 31, 2011

Re: Application for Disability Retirement - Corrections Officer Retirement Plan

Dear Mr. Smith:

Please be advised that the matter of your Application for Disability Retirement, based on a disability related to your back injury, is scheduled to be heard at the next regular meeting of the Local Board scheduled for 1:00 p.m. on September 22, 2011, at city hall, 123 E. North Street, Ocotillo, Arizona. A copy of the notice and the agenda for the meeting is enclosed.

A copy of Doctor Young's medical report, on which the Local Board will base their decision to approve or deny your application, is enclosed for your information. I would estimate that your matter will not be heard prior to 1:30 p.m.

At the hearing, the Local Board will convene in open session to consider your application. In making their determination, the Local Board will consider and discuss the medical evidence as well as other evidence which has been presented to them. Please be advised that the local board will discuss your confidential medical records only in executive session unless you have previously executed a waiver of confidentiality.

At the hearing, you may present any witnesses or evidence that you desire. I request that you submit any additional medical evidence to me as soon as possible so that this evidence can be given to the board members in advance of the meeting.

Although the board members will be supplied all the available medical evidence prior to the hearing, they will not discuss that evidence or meet about it before the meeting. The board members will actually discuss the medical evidence only at the hearing and you may be present during that discussion.

At the conclusion of the hearing, the board members will vote in open session on whether your Accidental Disability Application should be approved or denied.

If you have any further questions in this matter, please feel free to contact me.

Sincerely,

Local Board Secretary

Enclosures

FORM C5-LB-A
08/11

CORRECTIONS OFFICER RETIREMENT PLAN
3010 E. Camelback Rd., Suite 200, Phoenix, AZ 85016
(602) 255-5575 FAX (602) 296-2369 www.psprs.com

**ACCIDENTAL
DISABILITY QUESTIONNAIRE**
Completed by Local Board and Doctor (if applicable)

Pursuant to A.R.S. §§ 38-881(1) and 38-886, an "Accidental disability" means a physical or mental condition that the local board finds totally and permanently prevents an employee from performing a reasonable range of duties within the employee's department, was incurred in the performance of the employee's duties and was a result of physical contact with inmates, prisoners, parolees or persons on probation, responding to a confrontational situation with inmates, prisoners, parolees or persons on probation, or a job-related motor vehicle accident while on official business for the employee's employer.	LOCAL BOARD Initial Response			
1. Did the employee file the application after the disabling incident or within one year of ceasing to be an employee?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
YES		NO		
2. Is the employee still working in a job the board believes is a reasonable range of duties?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
YES		NO		
3. Does the employer have any jobs available for the employee the board believes is a reasonable range of duties position? (Submit job descriptions and duties to the doctor if sent for IME.)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
YES		NO		
4. Did the employer terminate the employee's employment based on a physical or mental condition?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
YES		NO		
5. Did the employer terminate the employee's employment based on a disciplinary issue?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
YES		NO		
6. Did the member terminate employment based on a physical or mental condition?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
YES		NO		
7. Did the member terminate employment based on election to participate in Reverse DROP?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
YES		NO		
8. Has the member refused a job the board believes is a reasonable range of duties?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
YES		NO		
9. Was the injury the result of an event incurred during the performance of the member's duty detailed above?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
YES		NO		
LOCAL BOARD INSTRUCTIONS: If it is determined that the employee does not qualify, complete FORM C5-LB and forward to CORP. If evidence exists that the employee may qualify and no reasonable range of duty jobs are available, a medical examination (IME) will need to be performed. Sign/date this questionnaire and forward the ORIGINAL (along with the all medical evidence and any additional questions) to the doctor.				
DOCTOR INSTRUCTIONS: In addition to the IME report, answer the following questions, sign/date and return the ORIGINAL to the Local Board. Provide additional comments in the IME report.	DOCTOR Initial Response			
1. Does the member have the physical condition that is the basis for the disability application?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
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2. Does the member have the mental condition that is the basis for the disability application?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
YES		NO		
3. Did the condition permanently prevent the member from performing a reasonable range of duties within the employee's department?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
YES		NO		
4. Did the condition totally prevent the member from performing a reasonable range of duties within the employee's department?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
YES		NO		
5. Did your review include a medical report describing any conditions or injuries that existed prior to membership in the pension system? If yes, address in IME report.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
YES		NO		
6. Did your review find any pre-existing conditions or injuries that played a role in the disability claimed by the member? If yes, address in IME report.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
YES		NO		
7. Was the injury a result of an event incurred during the performance of the member's duty detailed above?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
YES		NO		
8. Are there conflicts in the medical evidence? If yes, address in IME report.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">YES</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">NO</td> </tr> </table>	YES		NO
YES		NO		
LOCAL BOARD: If conflicts in the medical evidence, address if and how they were resolved in the Local Board meeting minutes. LOCAL BOARD AND DOCTOR: By my signature below, I attest that the medical records have been thoroughly reviewed, each section/questions have been answered by the appropriate party indicated above, and the information contained herein is true, complete and correct to the best of my knowledge and belief.				
PRINT Name of Local Board Secretary or Chairman	Signature	Date		
PRINT Doctor Name	Signature	Date		

CORRECTIONS OFFICER RETIREMENT PLAN

FORM C5-LB-TP

3010 E. Camelback Rd., Suite 200, Phoenix, AZ 85016

08/11

(602) 255-5575 FAX (602) 296-2369 www.psprs.com

**TOTAL AND PERMANENT
DISABILITY QUESTIONNAIRE**

Completed by Local Board and Doctor (if applicable)

Pursuant to A.R.S. §§ 38-881(44) and 38-886, a "Total and Permanent disability" means a physical condition or mental condition (<i>that is not an accidental disability</i>) that the local board finds totally and permanently prevents a member from engaging in any gainful employment and is in the direct and proximate result of the member's performance of the member's duties.	LOCAL BOARD Initial Response				
1. Did the employee file the application after the disabling incident or within one year of ceasing to be an employee?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
YES			NO		
2. Did the employer terminate the member's employment based on a physical or mental condition that is being applied for?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
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3. Did the employer terminate the employee's employment based on a disciplinary issue?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
YES			NO		
4. Did the member terminate employment based on a physical or mental condition?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
YES			NO		
5. Did the member terminate employment based on election to participate in Reverse DROP?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
YES			NO		
6. Is the member still working in a job the board believes is gainful employment?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
YES			NO		
7. Has the member refused a job the board believes is gainful employment?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
YES			NO		
8. Was the condition the direct and proximate result of the member's duty?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
YES			NO		
9. Did the condition or injury occur prior to the member's membership in the Plan?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
YES			NO		
LOCAL BOARD INSTRUCTIONS: If it is determined that the employee does not qualify, complete FORM C5-LB and forward to CORP. If evidence exists that the employee may qualify and no reasonable range of duty jobs are available, a medical examination (IME) will need to be performed. Sign/date this questionnaire and forward the ORIGINAL (along with the all medical evidence and any additional questions) to the doctor.					
DOCTOR INSTRUCTIONS: In addition to the IME report, answer the following questions, sign/date and return the ORIGINAL to the Local Board. Provide additional comments in the IME report.	DOCTOR Initial Response				
1. Does the member have the physical condition that is the basis for the disability application?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
YES			NO		
2. Does the member have the mental condition that is the basis for the disability application?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
YES			NO		
3. Does the condition totally prevent the member from engaging in any gainful employment?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
YES			NO		
4. Does the condition permanently prevent the member from engaging in any gainful employment?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
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YES			NO		
6. Did any pre-existing conditions or injuries play a role in the disability claimed by the member? If yes, address in IME report.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
YES			NO		
7. Did your review determine the member may be able to return to work in the next 12 months? If no, address in the IME report.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
YES			NO		
8. Was the condition or injury in the direct and proximate result of the member's performance of their duties?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
YES			NO		
9. Are there conflicts in the medical evidence? If yes, address in IME report.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">YES</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">NO</td> </tr> </table>	YES			NO
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LOCAL BOARD: If conflicts in the medical evidence, address if and how they were resolved in the Local Board meeting minutes. LOCAL BOARD AND DOCTOR: By my signature below, I attest that the medical records have been thoroughly reviewed, each section/questions have been answered by the appropriate party indicated above, and the information contained herein is true, complete and correct to the best of my knowledge and belief.					
PRINT Name of Local Board Secretary or Chairman	Signature	Date			
PRINT Doctor Name	Signature	Date			

CORRECTIONS OFFICER RETIREMENT PLAN

FORM C5-LB-O

3010 E. Camelback Rd., Suite 200, Phoenix, AZ 85016

08/11

(602) 255-5575 FAX (602) 296-2369 www.psprs.com

**ORDINARY
DISABILITY QUESTIONNAIRE**

Completed by Local Board and Doctor (if applicable)

Pursuant to A.R.S. §§ 38-881(30) and 38-886.01, an "Ordinary disability" means a physical condition that the local board determines will totally and permanently prevent an employee from performing a reasonable range of duties within the employee's department or a mental condition that the local board determines will totally and permanently prevent an employee from engaging in any substantial gainful activity.		LOCAL BOARD Initial Response	
1. Did the employee file the application after the disabling incident or within one year of ceasing to be an employee?	<input type="checkbox"/>	YES	<input type="checkbox"/>
2. Does the employer have any jobs available for the member the board believes is a reasonable range of duties position? (Submit job descriptions and duties to doctor.)	<input type="checkbox"/>	YES	<input type="checkbox"/>
3. Has the member refused a job the board believes is a reasonable range of duties?	<input type="checkbox"/>	YES	<input type="checkbox"/>
4. Did the employer terminate the employee's employment based on a physical or mental condition that is being applied for?	<input type="checkbox"/>	YES	<input type="checkbox"/>
5. Did the employer terminate the employee's employment based on a disciplinary issue?	<input type="checkbox"/>	YES	<input type="checkbox"/>
6. Did the member terminate employment based on a physical or mental condition?	<input type="checkbox"/>	YES	<input type="checkbox"/>
7. Did the member terminate employment based on election to participate in Reverse DROP?	<input type="checkbox"/>	YES	<input type="checkbox"/>
8. Does the physical condition totally prevent the member from performing a reasonable range of duties within the employee's department?	<input type="checkbox"/>	YES	<input type="checkbox"/>
9. Does the physical condition permanently prevent the member from performing a reasonable range of duties within the employee's department?	<input type="checkbox"/>	YES	<input type="checkbox"/>
10. Does the mental condition totally prevent the member from engaging in any substantial gainful activity?	<input type="checkbox"/>	YES	<input type="checkbox"/>
11. Does the mental condition permanently prevent the member from engaging in any substantial gainful activity?	<input type="checkbox"/>	YES	<input type="checkbox"/>
LOCAL BOARD INSTRUCTIONS: If it is determined that the employee does not qualify, complete FORM C5-LB and forward to CORP. If evidence exists that the employee may qualify and no reasonable range of duty jobs are available, a medical examination (IME) will need to be performed. Sign/date this questionnaire and forward the ORIGINAL (along with the all medical evidence and any additional questions) to the doctor.			
DOCTOR INSTRUCTIONS: In addition to the IME report, answer the following questions, sign/date and return the ORIGINAL to the Local Board. Provide additional comments in the IME report.		DOCTOR Initial Response	
1. Does the member have the physical or mental condition that is the basis for the disability application?	<input type="checkbox"/>	YES	<input type="checkbox"/>
2. Does the physical condition permanently prevent the member from performing a reasonable range of duties within the employee's department?	<input type="checkbox"/>	YES	<input type="checkbox"/>
3. Does the physical condition totally prevent the member from performing a reasonable range of duties within the employee's department?	<input type="checkbox"/>	YES	<input type="checkbox"/>
4. Does the mental condition totally prevent the member from engaging in any substantial gainful activity?	<input type="checkbox"/>	YES	<input type="checkbox"/>
5. Does the mental condition permanently prevent the member from engaging in any substantial gainful activity?	<input type="checkbox"/>	YES	<input type="checkbox"/>
6. Are there conflicts in the medical evidence? If yes, address in IME report.	<input type="checkbox"/>	YES	<input type="checkbox"/>
LOCAL BOARD: If conflicts in the medical evidence, address if and how they were resolved in the Local Board meeting minutes. LOCAL BOARD AND DOCTOR: By my signature below, I attest that the medical records have been thoroughly reviewed, each section/questions have been answered by the appropriate party indicated above, and the information contained herein is true, complete and correct to the best of my knowledge and belief.			
PRINT Name of Local Board Secretary or Chairman	Signature		Date
PRINT Doctor Name	Signature		Date

SPECIAL TAX NOTICE REGARDING PLAN PAYMENTS

This notice explains how you can continue to defer federal income tax on your retirement savings in the Public Safety Personnel Retirement System, Corrections Officer Retirement Plan or Elected Officials' Retirement Plan (the "Plan") and contains important information you will need before you decide how to receive your Plan benefits. Because PSPRS cannot provide you with tax advice and tax rules are complex, you may wish to consult a qualified tax professional before you made a withdrawal decision.

Your Right to Waive the 30-Day Notice Period. After receiving this notice, you have at least 30 days to consider whether or not to have your withdrawal directly rolled over. If you do not wish to wait until this 30-day notice period ends before your election is processed, you may waive the notice period by making an affirmative election on the appropriate application indicating whether or not you wish to make a direct rollover. Your withdrawal will then be processed in accordance with your election as soon as practical.

YOUR ROLLOVER OPTIONS

You are receiving this notice because all or a portion of a payment you are receiving from the "Plan" is eligible to be rolled over to an IRA or an eligible employer plan. This notice is intended to help you decide whether to do such a rollover. The term "IRA" as used in this notice includes only traditional IRAs and individual retirement annuities. It does not include Roth IRAs, SIMPLE IRAs or Coverdell Education Savings Accounts. An "eligible employer plan" includes a plan qualified under section 401(a) of the Internal Revenue Code, including a 401(k) plan, profit-sharing plan, defined benefit plan, stock bonus plan, and money purchase plan; a section 403(b) tax sheltered annuity plan; and an eligible section 457(b) plan maintained by a governmental employer (governmental 457 plan).

Rules that apply to most payments from a plan are described in the "General Information about Rollovers" section. Special rules that only apply in certain circumstances are described in the "Special Rules and Options" section.

GENERAL INFORMATION ABOUT ROLLOVERS

How can a rollover affect my taxes?

You will be taxed on a payment from the Plan if you do not roll it over. If you are under age 59 ½ and do not rollover, you will also have to pay a 10% additional income tax on early

distributions (unless an exception applies). However, if you do a rollover, you will not have to pay tax until you receive payments later and the 10% additional income tax will not apply if those payments are made after you are age 59 ½ (or if an exception applies).

Where may I roll over the payment?

You may roll over the payment to either an IRA (an individual retirement account or individual retirement annuity) or an employer plan (a tax-qualified plan, section 403(b) plan, or governmental 457(b) plan) that will accept the rollover. The rules of the IRA or employer plan that holds the rollover will determine your investment options, fees, and rights to payment from the IRA or employer plan (for example, no spousal consent rules apply to IRAs and IRAs may not provide loans). Further, the amount rolled over will become subject to the tax rules that apply to the IRA or employer plan.

How do I do a rollover?

There are two ways to do a rollover. You can do either a direct rollover or a 60-day rollover.

If you do a direct rollover, the Plan will make the payment directly to your IRA or an employer plan. You should contact the IRA sponsor or the administrator of the employer plan for information on how to do a direct rollover.

If you do not do a direct rollover, you may still do a rollover by making a deposit into an IRA or eligible employer plan that will accept it. You will have 60 days after you receive the payment to make the deposit. If you do not do a direct rollover, the Plan is required to withhold 20% of the payment for federal income taxes. This means that, in order to roll over the entire payment in a 60-day rollover, you must use other funds to make up for the 20% withheld. If you do not roll over the entire amount of the payment, the portion not rolled over will be taxed and will be subject to the 10% additional income tax on early distributions if you are under age 59 ½ (unless an exception applies).

How much may I roll over?

If you wish to do a rollover, you may roll over all or part of the amount eligible for rollover. Any payment from the Plan is eligible for rollover, except:

- Certain payments spread over a period of at least 10 years or over your life or life expectancy.
- Required minimum distributions after age 70 ½ (or after death).
- Corrective distributions of contributions that exceed tax law limitations.

- After-tax contributions. (At this time the Plan has not been amended to allow such contributions to be rolled over).

The Plan administrator or the payer can tell you what portion of a payment is eligible for rollover.

If I don't do a rollover, will I have to pay the 10% additional income tax on early distributions?

If you are under age 59 1/2, you will have to pay the 10% additional income tax on early distributions for any payment from the Plan (including amounts withheld for income tax) that you do not roll over, unless one of the exceptions listed below applies. This tax is in addition to the regular income tax on the payment not rolled over.

The 10% additional income tax does not apply to the following payments from the Plan:

- Payments made after you separate from service if you will be at least age 55 in the year of separation
- Payments that start after you separate from service if paid at least annually in equal or close to equal amounts over your life or life expectancy (or the lives or joint life expectancy of you and your beneficiary)
- Payments from a governmental defined benefit pension plan made after you separate from service if you are a public safety employee and you are at least age 50 in the year of separation
- Payments made due to disability
- Payments after your death
- Corrective distributions of contributions that exceed tax law limitations
- Payments made directly to the government to satisfy a federal tax levy
- Payments made under a qualified domestic relations order (QDRO)
- Payments up to the amount of your deductible medical expenses
- Certain payments made while you are on active duty if you were a member of a reserve component called to duty after September 11, 2001 for more than 179 days.

If I do a rollover to an IRA, will the 10% additional income tax apply to early distributions from the IRA?

If you receive a payment from an IRA when you are under age 59 1/2, you will have to pay the 10% additional income tax on early distributions from the IRA, unless an exception applies. In general, the exceptions to the 10% additional income tax for early distributions from an IRA are

the same as the exceptions listed above for early distributions from a plan. However, there are a few differences for payments from an IRA, including:

- There is no exception for payments after separation from service that are made after age 55.
- The exception for qualified domestic relations orders (QDROs) does not apply (although a special rule applies under which, as part of a divorce or separation agreement, a tax-free transfer may be made directly to an IRA of a spouse or former spouse).
- The exception for payments made at least annually in equal or close to equal amounts over a specified period applies without regard to whether you have had a separation from service.
- There are additional exceptions for (1) payments for qualified higher education expenses, (2) payments up to \$10,000 used in a qualified first-time home purchase, and (3) payments after you have received unemployment compensation for 12 consecutive weeks (or would have been eligible to receive unemployment compensation but for self-employed status).

Will I owe State income taxes?

This notice does not describe any State or local income tax rules (including withholding rules).

SPECIAL RULES AND OPTIONS

If your payment includes after-tax contributions

After-tax contributions included in a payment are not taxed. You will receive a separate payment for the after-tax contributions. At this writing the Plan does not have the authority to allow a direct rollover of your after-tax contributions.

If you miss the 60-day rollover deadline

Generally, the 60-day rollover deadline cannot be extended. However, the IRS has the limited authority to waive the deadline under certain extraordinary circumstances, such as when external events prevented you from completing the rollover by the 60-day rollover deadline. To apply for a waiver, you must file a private letter ruling request with the IRS. Private letter ruling requests require the payment of a nonrefundable user fee. For more information, see IRS Publication 590, Individual Retirement Arrangements (IRAs).

If you were born on or before January 1, 1936

If you were born on or before January 1, 1936 and receive a lump sum distribution that you do not roll over, special rules for calculating the amount of tax on the payment might apply to you. For more information, see IRS Publication 575, Pension and Annuity Income.

If you are an eligible retired public safety officer and your pension payment is used to pay for health coverage or qualified long-term care insurance

If the Plan is a governmental plan, you retired as a public safety officer, and your retirement was by reason of disability or was after normal retirement age, you can exclude from your taxable income plan payments paid directly as premiums to an accident or health plan (or a qualified long-term care insurance contract) that your employer maintains for you, your spouse, or your dependents, up to a maximum of \$3,000 annually. For this purpose, a public safety officer is a law enforcement officer, firefighter, chaplain, or member of a rescue squad or ambulance crew.

If you are not a plan participant

Payments after death of the participant. If you receive a distribution after the participant's death that you do not roll over, the distribution will generally be taxed in the same manner described elsewhere in this notice. However, the 10% additional income tax on early distributions and the special rules for public safety officers do not apply, and the special rule described under the section "If you were born on or before January 1, 1936" applies only if the participant was born on or before January 1, 1936.

If you are a surviving spouse. If you receive a payment from the Plan as the surviving spouse of a deceased participant, you have the same rollover options that the participant would have had, as described elsewhere in this notice. In addition, if you choose to do a rollover to an IRA, you may treat the IRA as your own or as an inherited IRA.

An IRA you treat as your own is treated like any other IRA of yours, so that payments made to you before you are age 59 ½ will be subject to the 10% additional income tax on early distributions (unless an exception applies) and required minimum distributions from your IRA do not have to start until after you are age 70 ½.

If you treat the IRA as an inherited IRA, payments from the IRA will not be subject to the 10% additional income tax on early distributions. However, if the participant had started taking required minimum distributions, you will have to receive required minimum distributions from the inherited IRA. If the participant had not started taking

required minimum distributions from the Plan, you will not have to start receiving required minimum distributions from the inherited IRA until the year the participant would have been age 70 ½.

If you are a surviving beneficiary other than a spouse. If you receive a payment from the Plan because of the participant's death and you are a designated beneficiary other than a surviving spouse, the only rollover option you have is to do a direct rollover to an inherited IRA. Payments from the inherited IRA will not be subject to the 10% additional income tax on early distributions. You will have to receive required minimum distributions from the inherited IRA.

Payments under a qualified domestic relations order. If you are the spouse or former spouse of the participant who receives a payment from the Plan under a qualified domestic relations order (QDRO), you generally have the same options the participant would have (for example, you may roll over the payment to your own IRA or an eligible employer plan that will accept it). Payments under the QDRO will not be subject to the 10% additional income tax on early distributions.

Other special rules

If your payments for the year are less than \$200, the Plan is not required to allow you to do a direct rollover and is not required to withhold for federal income taxes. However, you may do a 60-day rollover.

You may have special rollover rights if you recently served in the U.S. Armed Forces. For more information, see IRS Publication 3, Armed Forces' Tax Guide.

FOR MORE INFORMATION

You may wish to consult with the Plan administrator or payer, or a professional tax advisor, before taking a payment from the Plan. Also, you can find more detailed information on the federal tax treatment of payments from employer plans in: IRS Publication 575, Pension and Annuity Income; and IRS Publication 590, Individual Retirement Arrangements (IRAs). These publications are available from a local IRS office, on the web at www.irs.gov, or by calling 1-800-TAX-FORM.

* * *

**PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
CORRECTIONS OFFICER RETIREMENT PLAN
ELECTED OFFICIALS' RETIREMENT PLAN**

3010 East Camelback Road, Suite 200
Phoenix, Arizona 85016-4416
www.psprs.com
(602) 255-5575

Form 8
08/11

Fax **OR** Mail form to:
Non-retired Fax
(602) 296-2368

Retired Fax
(602) 296-2369

BENEFICIARY DESIGNATION FORM

Section 6109 of the Internal Revenue Code mandates disclosure of your Social Security number (SSN). We will only use your SSN to obtain account information and to inform the Internal Revenue Service (IRS) of distributions and withholdings.

SECTION 1 – PRINT Information		
SSN	RETIREE SYSID (if known)	Status (check one) <input type="checkbox"/> Non-retired <input type="checkbox"/> Retired
Date of Birth (MM/DD/YYYY)	Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	If non-retired, provide employer:
Name (Last)	(First)	(Middle)
Address – City, State and ZIP Code +4		E-mail Address
Home Telephone # ()	Cell # ()	Work # ()
SECTION 2 – IMPORTANT Beneficiary Information		
<ul style="list-style-type: none"> • An AUTOMATIC survivor benefit will pay your: <ul style="list-style-type: none"> ○ Eligible Spouse. If you are currently receiving a monthly benefit, statute requires two consecutive years of marriage. ○ Eligible Child(ren) that is(are) unmarried, under the age of 18, and/or attending full-time school between the ages of 18 to 23 plus disabled child(ren) if disability occurred before the age of 23 and who is a dependent of the member. • If there is no eligible spouse or eligible child(ren), the balance of the applicable contributions, if any, will be paid to the named beneficiary(ies) indicated below. If there is no beneficiary, your Local Board will determine the next-of-kin. • Note: Divorce automatically terminates the ex-spouse as the member's beneficiary. To maintain an ex-spouse as a beneficiary, you must complete a <i>Beneficiary Designation Form</i> after the date of the divorce. 		
<input checked="" type="checkbox"/> Primary		
SSN	Name of Beneficiary (Last, First, Middle)	Relationship (check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Fiancé <input type="checkbox"/> Friend <input type="checkbox"/> Other
Birth Date (MM/DD/YYYY)	Address (City, State, ZIP Code +4)	Telephone # ()
Check ONE <input type="checkbox"/> Primary OR <input type="checkbox"/> Secondary (If not checked, the following beneficiary is a primary beneficiary)		
SSN	Name of Beneficiary (Last, First, Middle)	Relationship (check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Fiancé <input type="checkbox"/> Friend <input type="checkbox"/> Other
Birth Date (MM/DD/YYYY)	Address (City, State, ZIP Code +4)	Telephone # ()
Check ONE <input type="checkbox"/> Primary OR <input type="checkbox"/> Secondary (If not checked, the following beneficiary is a primary beneficiary)		
SSN	Name of Beneficiary (Last, First, Middle)	Relationship (check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Fiancé <input type="checkbox"/> Friend <input type="checkbox"/> Other
Birth Date (MM/DD/YYYY)	Address (City, State, ZIP Code +4)	Telephone # ()
SECTION 3 – REQUIRED Signature - If not previously provided and signing as a Power of Attorney or Guardian, provide our office with a complete copy of the appointment documentation.		
PRINT Witness Name (cannot be beneficiary stated above)	Witness Signature	Date
Member's Signature		Date

For additional beneficiaries, copy and attach this form. Check this box if there is an additional form.

**PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
CORRECTIONS OFFICER RETIREMENT PLAN
ELECTED OFFICIALS' RETIREMENT PLAN**

3010 East Camelback Road, Suite 200
Phoenix, Arizona 85016-4416
www.psprs.com
(602) 255-5575

Form 9
08/11

Fax **OR** Mail form to:
Non-retired Fax
(602) 296-2368

Retired Fax
(602) 296-2369

ADDRESS AND NAME CHANGE FORM

Section 6109 of the Internal Revenue Code mandates disclosure of your Social Security number (SSN). We will only use your SSN to obtain account information and to inform the Internal Revenue Service (IRS) of distributions and withholdings.

SECTION 1 – PRINT Information			
SSN		Status (check one) <input type="checkbox"/> Non-retired <input type="checkbox"/> Retired <input type="checkbox"/> Survivor/Guardian <input type="checkbox"/> Ex-spouse <input type="checkbox"/> Refunding	
RETIREE SYSID (if known)	Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	If non-retired, provide employer:	If ex-spouse, provide member's name:
Name (Last)		(First)	(Middle)
E-mail Address			Date of Birth (MM/DD/YYYY)
Home Telephone # ()		Cell # ()	Work # ()
SECTION 2 – PRIMARY Mailing Address			
Mailing Address			
City		State	ZIP Code +4
Secondary Address (if different from above)			
Address			
City		State	ZIP Code +4
SECTION 3 – PRINT Name Change – Include a copy of a legal document showing your name change (e.g., driver's license, marriage certificate, divorce decree, passport, etc.)			
Current Name (Last, First, Middle)		New Name (Last, First, Middle)	
REQUIRED Signature - If not previously provided and signing as a Power of Attorney or Guardian, provide our office with a complete copy of the appointment documentation.			
Signature			Date

We must receive a properly completed form by the 10th of the month in order to be processed that month.

APPLICATION FOR NORMAL RETIREMENT

DATE: ____/____/____

TO: LOCAL RETIREMENT BOARD

I, _____, hereby submit my application for retirement under the terms of the Arizona Corrections Officer Retirement Plan. I meet the minimum eligibility requirements for a normal retirement at time of termination; namely, (1) 20 or more years of service, (2) age 62 with 10 or more years of service, (3) a dispatcher with 25 years of service, or (4) the sum of my age and years of credited service equals at least 80 (A.R.S. Section 38-885.(B)). I am retiring on ____/____/____, acknowledging that the effective date of my retirement will be the first day of the month following the date of retirement, with payments beginning on or about the last day of that month (A.R.S. Section 38-890). If application is being made under a prior law, please state prior system law: _____

ADDRESS: _____ HOME PHONE NUMBER: (____) _____ - _____
 _____ WORK PHONE NUMBER: (____) _____ - _____
 EMAIL: _____ CELL PHONE NUMBER: (____) _____ - _____

SPOUSE

Name: _____ Date of Birth: ____/____/____ Date of Marriage: ____/____/____
 Social Security Number: _____ - _____ - _____

DEPENDENT CHILDREN

NAME	DATE OF BIRTH		IS CHILD DISABLED?		Is child 18-22 and in school fulltime?	
	/	/	YES	NO	YES	NO
_____	/	/	YES	NO	YES	NO
_____	/	/	YES	NO	YES	NO
_____	/	/	YES	NO	YES	NO
_____	/	/	YES	NO	YES	NO
_____	/	/	YES	NO	YES	NO

NOTE: Please provide a copy of:

1. Your Birth Certificate
2. Your Marriage Certificate
3. Your Spouse's Birth Certificate
4. Your Dependent Children's Birth Certificates
5. If Divorced during period of employment:
 - a. Photocopy of complete Divorce Decree, or
 - b. Certified Copy of Plan-Approved Domestic Relations Order
6. Medical Documentation for Disabled Children. (If applicable)

(NOTE: Please complete 2nd page)

APPLICATION FOR DEFERRED ANNUITY

TO: LOCAL RETIREMENT BOARD

DATE: ____/____/____

Having completed 10 or more years of credited service with the (employer name) _____,
and having attained age 62, I, (name) _____, hereby submit my application for a
deferred annuity under the terms of the Arizona Corrections Officer Retirement Plan (A.R.S. Section 38-911). I am terminating
on or have terminated on (date) ____/____/____, acknowledging that the effective date of my deferred annuity will
be the first day of the month following the date of application, with payments beginning on or about the last day of that month. I
also understand that if I die and I have accumulated contributions remaining in the system, those remaining accumulated
contributions will be paid to my designated beneficiary, if living, or to my nearest living kin as selected by my local CORP board.

ADDRESS: _____

HOME PHONE NUMBER: (____) ____ - _____

WORK PHONE NUMBER:(____) ____ - _____

EMAIL: _____

CELL PHONE NUMBER:(____) ____ - _____

NOTE: Please provide a copy of:

1. Your Birth Certificate
2. Your Marriage Certificate
3. Your Spouse's Birth Certificate
4. Your Dependent Children's Birth Certificate
5. If Divorced during period of employment:
 - a. Photocopy of complete Divorce Decree, or
 - b. Certified copy of Plan-approved Domestic Relations Order

(NOTE: Please complete 2nd page)

APPLICATION FOR DISABILITY RETIREMENT
Completed by Employee

PRINT Employee/Member's Name		SSN	
Address		Date of Birth	
City, State and Zip Code		Email	
Home #	Cell #	Work #	

Employer _____ Service Date from _____ to _____

Break(s) in Service from _____ to _____ Break(s) in Service from _____ to _____

Type of Disability (check ONE): Accidental Total and Permanent Ordinary

Date of Disabling Event or Condition Diagnosis _____

Nature and Cause of Disability _____

List the doctors, hospitals and clinics who attended or examined your disability and three years prior
 (For additional doctors, attach a supplemental page)

Company Name	Company Name	Company Name
Doctor	Doctor	Doctor
Address	Address	Address
City, State, Zip+4	City, State, Zip+4	City, State, Zip+4
Phone	Phone	Phone
Illness	Illness	Illness

(For additional children, attach a supplemental page)

SPOUSE/CHILDREN: (Check box)		Print Name: (Last, First, Middle)	Date of Birth	Social Security Number	Disabled Child(ren)? Yes or No	Child(ren) 18-22 yrs in school fulltime? Yes or No
<input type="checkbox"/>	Spouse	<input type="checkbox"/> Not applicable				
<input type="checkbox"/>	Child	<input type="checkbox"/> Not applicable				
<input type="checkbox"/>	Child					
<input type="checkbox"/>	Child					

APPLICATION FOR DISABILITY RETIREMENT
Completed by Employee

REQUIRED AUTHORIZATIONS AND UNDERSTANDING – Initial the following:

_____ I authorize and request each physician and person in the medical or related fields, and each hospital, clinic, establishment and place rendering or having in the past rendered to me any medical or related service to allow the Local Board, the office of the Board of Trustees of the Corrections Officer Retirement Plan (CORP), their authorized designee, and/or each physician appointed by them to have, examine and/or copy, any and all information, records, reports and x-rays, regarding my physical and/or mental condition and treatment therefore.

_____ I authorize the Local Board, the office of the Board of Trustees and/or their authorized designee to procure from my employer(s) or from any other person, firm or corporation (including any governmental agency or department thereof) any and all information as directly related to leave(s) of absence without pay and/or application(s) for and/or receipt of Worker's Compensation Benefits. I expressly waive all provision of law forbidding any doctor, person, firm or corporation (including any governmental agency or department thereof) from disclosing any knowledge or information which they have in their possession concerning leave(s) of absence without pay and/or Worker's Compensation.

_____ I understand that pursuant to A.R.S. § 38-893(H), the Board of Trustees may perform a review of the disability retirements to ensure that the employee/member and the Local Board are in compliance with statutory requirements.

Authorizations are in effect from the date of this application to 120 days after first receipt of retirement benefits.

WAIVER OF CONFIDENTIALITY

_____ I hereby consent, upon the advice of counsel, that all matters and issues relating to my physical or mental condition or medical history, including, without limitation, whether my physical or mental condition arises from any preexisting disability, may be discussed and considered by the Board of Trustees and/or Local Board in open public meeting, and I hereby waive any right to have my physical or mental condition or medical history discussed and evaluated by the Board of Trustees and/or Local Board in executive session only. As part of the aforesaid waiver, I further consent that the Board of Trustees and/or Local Board may discuss and consider all evidence touching upon my physical or mental condition or medical history in open public session, including without limitation, testimony or records concerning my physical or mental condition or medical history from physicians or other expert witnesses, the social security administration, the state industrial commission, or other sources or persons of any kind or description. I understand that neither the Board of Trustees nor the Local Board has any obligation to keep confidential any information about my physical or mental condition or medical history that is discussed, presented or considered during any public session of the Board of Trustees or Local Board, and I absolve the Board of Trustees and Local Board from any liability arising from disclosure of such information during public session.

I hereby submit my application for a disability pension subject to all of the terms and conditions of the CORP. I attest that all information submitted is true, complete and correct to the best of my knowledge and belief. I understand that A.R.S. § 38-912(C) states: "A person who knowingly makes any false statement or who falsifies or permits to be falsified any record of the system with an intent to defraud the system is guilty of a class 5 felony."

_____/_____/_____
Date Employee/Member's Signature Local Board Representative Signature

REQUIRED DOCUMENTATION (as applicable, provide your Local Board with a copy):

- 1. Birth Certificate
- 2. Marriage Certificate
- 3. Spouse's Birth Certificate
- 4. Dependent Child(ren) Birth Certificates
- 5. If divorced during period of employment:
 - a. Photocopy of complete Divorce Decree, or
 - b. Certified copy of Plan-approved Domestic Relations Order
- 6. Medical documentation for disabled children.

Received Stamp or PRINT Name and Signature of Local Board Representative Date

LOCAL BOARD DETERMINATION FOR DISABILITY RETIREMENT
Completed by Local Board

PRINT Employee/Member's Name _____

SSN _____

LOCAL BOARD INSTRUCTIONS - Based on the "Type of Disability" selected by the employee on FORM C5-EE, complete the applicable *DISABILITY QUESTIONNAIRE* (i.e., FORM C5-LB-A, FORM C5-LB-TP, or C5-LB-O).

Employer _____

Termination Date _____ / _____ / _____ Last Day on Payroll _____ / _____ / _____

Service Date from _____ / _____ / _____ to _____ / _____ / _____

Service Break(s) from _____ / _____ / _____ to _____ / _____ / _____

Service Break(s) from _____ / _____ / _____ to _____ / _____ / _____

Work Status (Select all that apply) Working Full-time Working Part-time Not Working Regular Assignment Limited Duty Paid Leave Unpaid Leave Other _____

DETERMINATION - Pursuant to A.R.S. § 38-893, the attached *DISABILITY QUESTIONNAIRE* and Medical Examination (if applicable), the Local Board has determined that the employee/member:

- Does not qualify for a disability retirement.
- Qualifies for an ACCIDENTAL DISABILITY retirement pension effective _____ / _____ / _____
- Qualifies for a TOTAL AND PERMANENT retirement pension effective _____ / _____ / _____
- Qualifies for an ORDINARY DISABILITY retirement pension effective _____ / _____ / _____

PRINT Name of Local Board Secretary or Chairman _____

Signature _____

Board Meeting Motion Date _____

Pursuant to § 38-893(H), the Board of Trustees may perform a review of the disability retirements to ensure that the Employee/Member and the Local Board is in compliance with statutory requirements.

LOCAL BOARD: Return **ORIGINALS** of this (C5-LB) form, C5-EE, *DISABILITY QUESTIONNAIRE* and provide the Medical Examination (if applicable), Local Board meeting minutes and "REQUIRED DOCUMENTS" as indicated on FORM C5-EE.

**ACCIDENTAL
 DISABILITY QUESTIONNAIRE**

Completed by Local Board and Doctor (if applicable)

Pursuant to A.R.S. §§ 38-881(1) and 38-886, an "Accidental disability" means a physical or mental condition that the local board finds totally and permanently prevents an employee from performing a reasonable range of duties within the employee's department, was incurred in the performance of the employee's duties and was a result of physical contact with inmates, prisoners, parolees or persons on probation, responding to a confrontational situation with inmates, prisoners, parolees or persons on probation, or a job-related motor vehicle accident while on official business for the employee's employer.		LOCAL BOARD Initial Response	
1. Did the employee file the application after the disabling incident or within one year of ceasing to be an employee?		YES	NO
2. Is the employee still working in a job the board believes is a reasonable range of duties?		YES	NO
3. Does the employer have any jobs available for the employee the board believes is a reasonable range of duties position? (Submit job descriptions and duties to the doctor if sent for IME.)		YES	NO
4. Did the employer terminate the employee's employment based on a physical or mental condition?		YES	NO
5. Did the employer terminate the employee's employment based on a disciplinary issue?		YES	NO
6. Did the member terminate employment based on a physical or mental condition?		YES	NO
7. Did the member terminate employment based on election to participate in Reverse DROP?		YES	NO
8. Has the member refused a job the board believes is a reasonable range of duties?		YES	NO
9. Was the injury the result of an event incurred during the performance of the member's duty detailed above?		YES	NO
LOCAL BOARD INSTRUCTIONS: If it is determined that the employee does not qualify, complete FORM C5-LB and forward to CORP. If evidence exists that the employee may qualify and no reasonable range of duty jobs are available, a medical examination (IME) will need to be performed. Sign/date this questionnaire and forward the ORIGINAL (along with the all medical evidence and any additional questions) to the doctor.			
DOCTOR INSTRUCTIONS: In addition to the IME report, answer the following questions, sign/date and return the ORIGINAL to the Local Board. Provide additional comments in the IME report.		DOCTOR Initial Response	
1. Does the member have the physical condition that is the basis for the disability application?		YES	NO
2. Does the member have the mental condition that is the basis for the disability application?		YES	NO
3. Did the condition permanently prevent the member from performing a reasonable range of duties within the employee's department?		YES	NO
4. Did the condition totally prevent the member from performing a reasonable range of duties within the employee's department?		YES	NO
5. Did your review include a medical report describing any conditions or injuries that existed prior to membership in the pension system? If yes, address in IME report.		YES	NO
6. Did your review find any pre-existing conditions or injuries that played a role in the disability claimed by the member? If yes, address in IME report.		YES	NO
7. Was the injury a result of an event incurred during the performance of the member's duty detailed above?		YES	NO
8. Are there conflicts in the medical evidence? If yes, address in IME report.		YES	NO
LOCAL BOARD: If conflicts in the medical evidence, address if and how they were resolved in the Local Board meeting minutes. LOCAL BOARD AND DOCTOR: By my signature below, I attest that the medical records have been thoroughly reviewed, each section/questions have been answered by the appropriate party indicated above, and the information contained herein is true, complete and correct to the best of my knowledge and belief.			
PRINT Name of Local Board Secretary or Chairman	Signature	Date	
PRINT Doctor Name	Signature	Date	

CORRECTIONS OFFICER RETIREMENT PLAN

FORM C5-LB-TP

3010 E. Camelback Rd., Suite 200, Phoenix, AZ 85016

08/11

(602) 255-5575 FAX (602) 296-2369 www.psprs.com

**TOTAL AND PERMANENT
DISABILITY QUESTIONNAIRE**

Completed by Local Board and Doctor (if applicable)

Pursuant to A.R.S. §§ 38-881(44) and 38-886, a "Total and Permanent disability" means a physical condition or mental condition (<i>that is not an accidental disability</i>) that the local board finds totally and permanently prevents a member from engaging in any gainful employment and is in the direct and proximate result of the member's performance of the member's duties.		LOCAL BOARD Initial Response	
1. Did the employee file the application after the disabling incident or within one year of ceasing to be an employee?	YES	NO	
2. Did the employer terminate the member's employment based on a physical or mental condition that is being applied for?	YES	NO	
3. Did the employer terminate the employee's employment based on a disciplinary issue?	YES	NO	
4. Did the member terminate employment based on a physical or mental condition?	YES	NO	
5. Did the member terminate employment based on election to participate in Reverse DROP?	YES	NO	
6. Is the member still working in a job the board believes is gainful employment?	YES	NO	
7. Has the member refused a job the board believes is gainful employment?	YES	NO	
8. Was the condition the direct and proximate result of the member's duty?	YES	NO	
9. Did the condition or injury occur prior to the member's membership in the Plan?	YES	NO	
LOCAL BOARD INSTRUCTIONS: If it is determined that the employee does not qualify, complete FORM C5-LB and forward to CORP. If evidence exists that the employee may qualify, a medical examination (IME) will need to be performed. Sign/date this questionnaire and forward the ORIGINAL (along with the all medical evidence and any additional questions) to the doctor.			
DOCTOR INSTRUCTIONS: In addition to the IME report, answer the following questions, sign/date and return the ORIGINAL to the Local Board. Provide additional comments in the IME report.		DOCTOR Initial Response	
1. Does the member have the physical condition that is the basis for the disability application?	YES	NO	
2. Does the member have the mental condition that is the basis for the disability application?	YES	NO	
3. Does the condition totally prevent the member from engaging in any gainful employment?	YES	NO	
4. Does the condition permanently prevent the member from engaging in any gainful employment?	YES	NO	
5. Did your review include a medical report describing any conditions or injuries that existed prior to membership in the pension system? If yes, address in IME report.	YES	NO	
6. Did any pre-existing conditions or injuries play a role in the disability claimed by the member? If yes, address in IME report.	YES	NO	
7. Did your review determine the member may be able to return to work in the next 12 months? If no, address in the IME report.	YES	NO	
8. Was the condition or injury in the direct and proximate result of the member's performance of their duties?	YES	NO	
9. Are there conflicts in the medical evidence? If yes, address in IME report.	YES	NO	
LOCAL BOARD: If conflicts in the medical evidence, address if and how they were resolved in the Local Board meeting minutes. LOCAL BOARD AND DOCTOR: By my signature below, I attest that the medical records have been thoroughly reviewed, each section/questions have been answered by the appropriate party indicated above, and the information contained herein is true, complete and correct to the best of my knowledge and belief.			
PRINT Name of Local Board Secretary or Chairman	Signature	Date	
PRINT Doctor Name	Signature	Date	

**ORDINARY
 DISABILITY QUESTIONNAIRE**

Completed by Local Board and Doctor (if applicable)

Pursuant to A.R.S. §§ 38-881(30) and 38-886.01, an "Ordinary disability" means a physical condition that the local board determines will totally and permanently prevent an employee from performing a reasonable range of duties within the employee's department or a mental condition that the local board determines will totally and permanently prevent an employee from engaging in any substantial gainful activity.		LOCAL BOARD Initial Response	
1. Did the employee file the application after the disabling incident or within one year of ceasing to be an employee?		YES	NO
2. Does the employer have any jobs available for the member the board believes is a reasonable range of duties position? (Submit job descriptions and duties to doctor.)		YES	NO
3. Has the member refused a job the board believes is a reasonable range of duties?		YES	NO
4. Did the employer terminate the employee's employment based on a physical or mental condition that is being applied for?		YES	NO
5. Did the employer terminate the employee's employment based on a disciplinary issue?		YES	NO
6. Did the member terminate employment based on a physical or mental condition?		YES	NO
7. Did the member terminate employment based on election to participate in Reverse DROP?		YES	NO
8. Does the physical condition totally prevent the member from performing a reasonable range of duties within the employee's department?		YES	NO
9. Does the physical condition permanently prevent the member from performing a reasonable range of duties within the employee's department?		YES	NO
10. Does the mental condition totally prevent the member from engaging in any substantial gainful activity?		YES	NO
11. Does the mental condition permanently prevent the member from engaging in any substantial gainful activity?		YES	NO
LOCAL BOARD INSTRUCTIONS: If it is determined that the employee does not qualify, complete FORM C5-LB and forward to CORP. If evidence exists that the employee may qualify and no reasonable range of duty jobs are available, a medical examination (IME) will need to be performed. Sign/date this questionnaire and forward the ORIGINAL (along with the all medical evidence and any additional questions) to the doctor.			
DOCTOR INSTRUCTIONS: In addition to the IME report, answer the following questions, sign/date and return the ORIGINAL to the Local Board. Provide additional comments in the IME report.		DOCTOR Initial Response	
1. Does the member have the physical or mental condition that is the basis for the disability application?		YES	NO
2. Does the physical condition permanently prevent the member from performing a reasonable range of duties within the employee's department?		YES	NO
3. Does the physical condition totally prevent the member from performing a reasonable range of duties within the employee's department?		YES	NO
4. Does the mental condition totally prevent the member from engaging in any substantial gainful activity?		YES	NO
5. Does the mental condition permanently prevent the member from engaging in any substantial gainful activity?		YES	NO
6. Are there conflicts in the medical evidence? If yes, address in IME report.		YES	NO
LOCAL BOARD: If conflicts in the medical evidence, address if and how they were resolved in the Local Board meeting minutes. LOCAL BOARD AND DOCTOR: By my signature below, I attest that the medical records have been thoroughly reviewed, each section/questions have been answered by the appropriate party indicated above, and the information contained herein is true, complete and correct to the best of my knowledge and belief.			
PRINT Name of Local Board Secretary or Chairman	Signature	Date	
PRINT Doctor Name	Signature	Date	

APPLICATION FOR DEATH BENEFIT

DATE: ____/____/____

TO: LOCAL RETIREMENT BOARD

I hereby submit my application for a death benefit under the terms of the Corrections Officer Retirement Plan.

NAME OF DECEASED MEMBER: _____ DATE OF DEATH: ____/____/____

APPLICANT'S NAME: _____

SOCIAL SECURITY NUMBER: ____-____-____ DATE OF BIRTH: ____/____/____

RELATIONSHIP TO DECEASED: Designated Beneficiary Personal Representative of Decedent's Estate

MAILING ADDRESS: _____
(Street) (Apt. No.) (City) (State) (Zip)

HOME PHONE NUMBER: (____) ____-____ WORK PHONE NUMBER: (____) ____-____

EMAIL: _____ CELL PHONE NUMBER: (____) ____-____

Enclose:	Copy of Death Certificate Copy of Applicant's Driver's License Certified Copy of Personal Representative letter (if applicable) Federal and State Withholding Forms Copy of Applicant's Social Security Card Form U3 Benefits Lump Sum Distribution (if applicable) Special Tax Notice Copy to Applicant (if applicable)
-----------------	--

The information contained in this application is true, complete and correct to the best of my knowledge and belief.

Witness Signature Signature of Designated Beneficiary or Personal Representative

Final contribution amount to CORP _____ **for Pay Period Ending:** _____

Employer: _____

____/____/____
Date Received by Employer

Signature of Employer

Total amount of benefit \$ _____

The Local Retirement Board has met on _____ and determined that the applicant above is eligible for the benefit payments as shown above: (date)

Name of Board

Signature of Board Chairman

APPLICATION FOR A SURVIVOR'S BENEFIT

DATE: ____/____/____

TO: LOCAL RETIREMENT BOARD

I hereby submit my application for a survivor's benefit under the terms of the Arizona Corrections Officer Retirement Plan.

NAME OF DECEASED MEMBER: _____ DATE OF DEATH: ____/____/____

RELATIONSHIP TO DECEASED: SURVIVING SPOUSE GUARDIAN OF DECEDENT'S DEPENDENT CHILDREN

SURVIVING SPOUSE:

NAME: _____ DATE OF BIRTH: ____/____/____

SOCIAL SECURITY NUMBER: ____-____-____ DATE OF MARRIAGE: ____/____/____

MAILING ADDRESS: _____

HOME PHONE NUMBER: (____) ____-____ WORK PHONE NUMBER: (____) ____-____

EMAIL: _____ CELL PHONE NUMBER: (____) ____-____

GUARDIAN:

NAME: _____ SOCIAL SECURITY NUMBER: ____-____-____

DATE OF BIRTH: ____/____/____

MAILING ADDRESS: _____

HOME PHONE NUMBER: (____) ____-____ WORK PHONE NUMBER: (____) ____-____

EMAIL: _____ CELL PHONE NUMBER: (____) ____-____

SURVIVING CHILDREN OF DECEASED:

DEPENDENT CHILDREN

NAME	DATE OF BIRTH	IS CHILD DISABLED?		Is child 18-22 and in school fulltime?	
		YES	NO	YES	NO
_____	____/____/____	YES	NO	YES	NO
_____	____/____/____	YES	NO	YES	NO
_____	____/____/____	YES	NO	YES	NO
_____	____/____/____	YES	NO	YES	NO
_____	____/____/____	YES	NO	YES	NO

NOTE: Please provide a copy of:

1. Death Certificate
2. Birth Certificate (for spouse, dependent children, and guardian)
3. Marriage Certificate (if applicable)
4. Proof of Legal Guardianship (if applicable)
5. Medical Documentation for Disabled Children. (If applicable)
6. Proof of Fulltime School Enrollment (If applicable)
7. Social Security Card

The information contained in this application is true, complete and correct to the best of my knowledge and belief.

 Witness Signature

 Signature of Spouse or Guardian

 Employer

 Signature of Employer

 Date Received by Employer

CORRECTIONS OFFICER RETIREMENT PLAN

FORM C11A

3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016

Page 1 of 1

(602)255-5575 FAX (602)296-2369 www.psprs.com

08/11

BENEFIT CALCULATIONS
(A.R.S. Section 38-781 as Amended)

USE THIS FORM TO CALCULATE NORMAL SERVICE RETIREMENT BENEFITS

***** MEMBER MUST HAVE WORKED WITH EMPLOYER PRIOR TO CORP JOINDER DATE OF JULY 1, 1986 *****

MEMBER'S NAME: _____ EMPLOYER: _____

BIRTH DATE: ____/____/____ SOCIAL SECURITY NUMBER: _____-____-_____

SERVICE DATES: FROM ____/____/____ THROUGH ____/____/____

AMOUNT OF FINAL CONTRIBUTION MADE TO CORP \$_____ FOR PAY PERIOD ENDING _____

Years of Service: _____ years _____ days ÷ 365 days = _____ years

Prior Service: _____ years _____ days ÷ 365 days = _____ years

Less NON-CREDITED SERVICE: (____) years (____) days ÷ 365 days = (____) years

TOTAL LENGTH OF CREDITED SERVICE: _____ years _____ days ÷ 365 days = _____ years

A. NORMAL RETIREMENT BENEFIT

1. **BASE SALARY** paid to member during a period of 36 consecutive months of credited service in which member received highest base salary within the last 120 months of service:

<u>YEAR</u>	<u>AMOUNT</u>	<u>YEAR</u>	<u>AMOUNT</u>
_____ through _____	\$ _____	_____ through _____	\$ _____
_____ through _____	\$ _____	_____ through _____	\$ _____
_____ through _____	\$ _____	_____ through _____	\$ _____
_____ through _____	\$ _____	_____ through _____	\$ _____

2. Total amount of highest 36 consecutive months of base salary: \$ _____

3. Average monthly salary: (A.2 ÷ 36 months) = \$ _____

4. Normal Retirement Benefits: 2% (.02) multiplied by years of credited service (include fractional years up to a maximum of 37.5 years) (02 x _____ years) = \$ _____

5. TOTAL MONTHLY BENEFIT FOR NORMAL RETIREMENT: (A.3 x A.4) = \$ _____

6. Early Retirement factor _____ x A.5 = \$ _____

OPTION # 2 5-Year Certain Factor _____ x A.5 or A.6 = \$ _____

OPTION # 3 10-Year Certain Factor _____ x A.5 or A.6 = \$ _____

OPTION # 4 100% Survivor Factor _____ x A.5 or A.6 = \$ _____

OPTION # 5 66 2/3 Survivor Factor _____ x A.5 or A.6 = \$ _____

OPTION # 6 1/2 Survivor Factor _____ x A.5 or A.6 = \$ _____

OPTION # 7 15-Year Certain Factor _____ x A.5 or A.6 = \$ _____

Calculated by: _____ Date: ____/____/____

Phone Number: _____

**PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
CORRECTIONS OFFICER RETIREMENT PLAN
ELECTED OFFICIALS' RETIREMENT PLAN**

3010 East Camelback Road, Suite 200
Phoenix, Arizona 85016-4416
www.psprs.com
(602) 255-5575

Form 13
08/11

Fax OR Mail form to:
Non-retired Fax
(602) 296-2368

Retired Fax
(602) 296-2369

AUTHORIZATION TO START OR CANCEL DIRECT DEPOSIT

Section 6109 of the Internal Revenue Code mandates disclosure of your Social Security number (SSN). We will only use your SSN to obtain account information and to inform the Internal Revenue Service (IRS) of distributions and withholdings.

SECTION 1 – PRINT Information			
SSN		Status (check one) <input type="checkbox"/> Retired <input type="checkbox"/> Survivor/Guardian <input type="checkbox"/> Ex-spouse <input type="checkbox"/> Refunding	
RETIREE SYSID (if known)	Date of Birth (MM/DD/YYYY)	Gender (Check One) <input type="checkbox"/> Male <input type="checkbox"/> Female	If ex-spouse, provide member's name:
Name (Last)		(First)	(Middle)
Address – City, State, ZIP Code +4			E-mail Address
Home Telephone # ()	Cell # ()	Work # ()	

SECTION 2 – Bank Information - If you have more than one account, complete a new form for each account.

I authorize the deposit of my check(s) into the following account (replacing all prior requests):

Check only one: Checking OR Savings

Routing # and account # samples:

Routing # (9 digits): _____

:089400988: 00149843" 1438
ROUTING NUMBER ACCOUNT NUMBER CHECK NUMBER

Account #: _____

:089400988: 1438 3910 409843"
ROUTING NUMBER CHECK NUMBER ACCOUNT NUMBER

Financial Institution: _____

ATTACH A VOIDED CHECK (or copy) ON REVERSE SIDE
(or a letter from your financial institution verifying your name, account and routing numbers)
AND COPY OF YOUR DRIVER'S LICENSE (or ID card)

SECTION 3 – Cancellation of Direct Deposit

ONLY check this box if you want to **STOP** the direct deposit entirely and send your check(s) to your mailing address.

SECTION 4 – REQUIRED Signature - If not previously provided and signing as a Power of Attorney or Guardian, provide our office with a complete copy of the appointment documentation.

By my signature below, I authorize and understand that:

- The financial institution stated above will debit my account for the purpose of error corrections (upon written request to the financial institution by the PSPRS/CORP/EORP).
- Upon written request by the PSPRS/CORP/EORP, the financial institution stated above will release my address and/or general account information to the PSPRS/CORP/EORP. For example, this includes the name and address of any joint account holder(s), or legal representative(s) on the account.
- Any joint bank account holder(s) must immediately notify the financial institution and the PSPRS/CORP/EORP of the death of the member and must also return to the PSPRS/CORP/EORP any deposited funds that the member is not entitled to receive.
- This agreement remains in effect until canceled by me, in writing, or upon my death. The PSPRS/CORP/EORP reserves the right to discontinue or cancel this deposit at any time.

REQUIRED Signature	Date
---------------------------	-------------

We must receive a properly completed form by the 10th of the month in order to be processed that month.

For account information, visit our website at www.psprs.com under "Members Only."

Type or print your full name (last, first, middle initial)	Your social security number
Home address (number and street or rural route)	Annuity Contract Claim or I.D. Number
City or town, state, and ZIP code	Telephone Number

Annuitant's Voluntary Arizona Income Tax Withholding Options

Choose only one:

- 1 I hereby elect to have Arizona income taxes withheld from my annuity or pension payments as authorized by ARS §43-404.
I choose to have Arizona withholding at the rate of
(check only one box): 0.8% 1.3% 1.8% 2.7% 3.6% 4.2% 5.1% of the
taxable amount of distribution.

Additional amount to be withheld per distribution \$ _____

- 2 I hereby elect to terminate my prior election for voluntary Arizona income tax withholding from my annuity or pension payments as authorized by ARS §43-404.

I certify that I have made the percentage election marked above.	
_____	_____
SIGNATURE	DATE

GENERAL INSTRUCTIONS

Who May Use Form A-4P

A person who receives an annuity or pension may use this form to elect voluntary Arizona income tax withholding. Arizona withholding is a percentage of the taxable amount of distribution in Box 2a of federal Form 1099-R. Therefore, you may elect voluntary Arizona income tax withholding at the applicable percentage rates and designate an additional amount to be withheld.

"Annuity" means any amount paid to an individual as a pension or annuity, but only to the extent that the amount is includible in the Arizona gross income of that individual.

You may NOT elect to have Arizona income tax withheld from nonperiodic payments, lump sum distributions, or individual retirement account distributions, that do not meet the definition of annuity listed above.

You also may NOT elect to have Arizona income tax withheld from Social Security pensions, Veteran's Administration annuities, or Railroad Retirement pensions.

Where to Send Form A-4P

Send Form A-4P to the payor of your annuity or pension. Do not send Form A-4P to the Arizona Department of Revenue.

Duration of Voluntary Arizona Withholding Election

The payor of your pension or annuity will withhold Arizona income tax from your payments until you notify the payor to terminate Arizona withholding.

How to Terminate a Voluntary Arizona Withholding Election

You may terminate your voluntary Arizona withholding election at any time. You may use Form A-4P to terminate Arizona withholding or you may send a written notice to the payor of your pension or annuity requesting termination of withholding.

Statement of Income Tax Withheld

The payor of your pension or annuity will provide you with a form that lists the total amount of your pension or annuity payments and the total amount of Arizona income tax withheld from these payments for the calendar year 2012. The payor of your pension or annuity will provide this form to you in early 2013.

**Withholding Certificate for
 Pension or Annuity Payments**

2012

Purpose. Form W-4P is for U.S. citizens, resident aliens, or their estates who are recipients of pensions, annuities (including commercial annuities), and certain other deferred compensation. Use Form W-4P to tell payers the correct amount of federal income tax to withhold from your payment(s). You also may use Form W-4P to choose (a) not to have any federal income tax withheld from the payment (except for eligible rollover distributions or payments to U.S. citizens delivered outside the United States or its possessions) or (b) to have an additional amount of tax withheld.

Your options depend on whether the payment is periodic, nonperiodic, or an eligible rollover distribution, as explained on pages 3 and 4. Your previously filed Form W-4P will remain in effect if you do not file a Form W-4P for 2012.

What do I need to do? Complete lines **A** through **G** of the **Personal Allowances Worksheet**. Use the additional worksheets on page 2 to further adjust your withholding allowances for itemized deductions, adjustments to income, any additional standard deduction, certain credits, or multiple pensions/ more-than-one-income situations. If you do not want any federal income tax withheld (see *Purpose*, earlier), you can skip the worksheets and go directly to the Form W-4P below.

Sign this form. Form W-4P is not valid unless you sign it.

Future developments. The IRS has created a page on IRS.gov for information about Form W-4P and its instructions, at www.irs.gov/w4p. Information about any future developments affecting Form W-4P (such as legislation enacted after we release it) will be posted on that page.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent **A** _____

B Enter "1" if:
 { • You are single and have only one pension; or
 • You are married, have only one pension, and your spouse has no income subject to withholding; or
 • Your income from a second pension or a job or your spouse's pension or wages (or the total of all) is \$1,500 or less. } **B** _____

C Enter "1" for your **spouse**. But, you may choose to enter "-0-" if you are married and have either a spouse who has income subject to withholding or more than one source of income subject to withholding. (Entering "-0-" may help you avoid having too little tax withheld.) **C** _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return **D** _____

E Enter "1" if you will file as **head of household** on your tax return **E** _____

F Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
 • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to seven eligible children or **less** "2" if you have eight or more eligible children.
 • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child **F** _____

G Add lines A through F and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ► **G** _____

For accuracy, **complete all worksheets that apply.** {
 • If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
 • If you are **single and have more than one source of income subject to withholding** or are **married and you and your spouse both have income subject to withholding** and your combined income from all sources exceeds \$40,000 (\$10,000 if married), see the **Multiple Pensions/More-Than-One-Income Worksheet** on page 2 to avoid having too little tax withheld.
 • If **neither** of the above situations applies, **stop here** and enter the number from line G on line 2 of Form W-4P below.

----- Separate here and give Form W-4P to the payer of your pension or annuity. Keep the top part for your records. -----

**Withholding Certificate for
 Pension or Annuity Payments**

2012

► For Privacy Act and Paperwork Reduction Act Notice, see page 4.

Your first name and middle initial	Last name	Your social security number
Home address (number and street or rural route)		Claim or identification number (if any) of your pension or annuity contract
City or town, state, and ZIP code		

Complete the following applicable lines.

1 Check here if you **do not want any** federal income tax withheld from your pension or annuity. (Do not complete line 2 or 3.) ►

2 Total number of allowances and marital status you are claiming for withholding from each **periodic** pension or annuity payment. (You also may designate an additional dollar amount on line 3.) ► _____

Marital status: Single Married Married, but withhold at higher Single rate (Enter number of allowances.)

3 Additional amount, if any, you want withheld from each pension or annuity payment. (**Note.** For periodic payments, you cannot enter an amount here without entering the number (including zero) of allowances on line 2.) ► \$ _____

Your signature ► _____

Date ► _____

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2012 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	\$ _____
2	Enter: $\left\{ \begin{array}{l} \$11,900 \text{ if married filing jointly or qualifying widow(er)} \\ \$8,700 \text{ if head of household} \\ \$5,950 \text{ if single or married filing separately} \end{array} \right\}$	2	\$ _____
3	Subtract line 2 from line 1. If zero or less, enter “-0-”	3	\$ _____
4	Enter an estimate of your 2012 adjustments to income and any additional standard deduction (see Pub. 505)	4	\$ _____
5	Add lines 3 and 4 and enter the total. (Include any credit amounts from the <i>Converting Credits to Withholding Allowances for 2012 Form W-4</i> worksheet in Pub. 505.)	5	\$ _____
6	Enter an estimate of your 2012 income not subject to withholding (such as dividends or interest)	6	\$ _____
7	Subtract line 6 from line 5. If zero or less, enter “-0-”	7	\$ _____
8	Divide the amount on line 7 by \$3,800 and enter the result here. Drop any fraction	8	_____
9	Enter the number from the Personal Allowances Worksheet , line G, page 1	9	_____
10	Add lines 8 and 9 and enter the total here. If you use the Multiple Pensions/More-Than-One-Income Worksheet , also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4P, line 2, page 1	10	_____

Multiple Pensions/More-Than-One-Income Worksheet

Note. Complete *only* if the instructions under line G, page 1, direct you here. This applies if you (and your spouse if married filing jointly) have more than one source of income subject to withholding (such as more than one pension, or a pension and a job, or you have a pension and your spouse works).

1	Enter the number from line G, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet)	1	_____
2	Find the number in Table 1 below that applies to the LOWEST paying pension or job and enter it here. However , if you are married filing jointly and the amount from the highest paying pension or job is \$65,000 or less, do not enter more than “3”	2	_____
3	If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter “-0-”) and on Form W-4P, line 2, page 1. Do not use the rest of this worksheet	3	_____
Note. If line 1 is less than line 2, enter “-0-” on Form W-4P, line 2, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.			
4	Enter the number from line 2 of this worksheet	4	_____
5	Enter the number from line 1 of this worksheet	5	_____
6	Subtract line 5 from line 4	6	_____
7	Find the amount in Table 2 below that applies to the HIGHEST paying pension or job and enter it here	7	\$ _____
8	Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	\$ _____
9	Divide line 8 by the number of pay periods remaining in 2012. For example, divide by 12 if you are paid every month and you complete this form in December 2011. Enter the result here and on Form W-4P, line 3, page 1. This is the additional amount to be withheld from each payment	9	\$ _____

Table 1

Table 2

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job or pension are—	Enter on line 2 above	If wages from LOWEST paying job or pension are—	Enter on line 2 above	If wages from HIGHEST paying job or pension are—	Enter on line 7 above	If wages from HIGHEST paying job or pension are—	Enter on line 7 above
\$0 - \$5,000	0	\$0 - \$8,000	0	\$0 - \$70,000	\$570	\$0 - \$35,000	\$570
5,001 - 12,000	1	8,001 - 15,000	1	70,001 - 125,000	950	35,001 - 90,000	950
12,001 - 22,000	2	15,001 - 25,000	2	125,001 - 190,000	1,060	90,001 - 170,000	1,060
22,001 - 25,000	3	25,001 - 30,000	3	190,001 - 340,000	1,250	170,001 - 375,000	1,250
25,001 - 30,000	4	30,001 - 40,000	4	340,001 and over	1,330	375,001 and over	1,330
30,001 - 40,000	5	40,001 - 50,000	5				
40,001 - 48,000	6	50,001 - 65,000	6				
48,001 - 55,000	7	65,001 - 80,000	7				
55,001 - 65,000	8	80,001 - 95,000	8				
65,001 - 72,000	9	95,001 - 120,000	9				
72,001 - 85,000	10	120,001 and over	10				
85,001 - 97,000	11						
97,001 - 110,000	12						
110,001 - 120,000	13						
120,001 - 135,000	14						
135,001 and over	15						

Additional Instructions

Section references are to the Internal Revenue Code.

When should I complete the form? Complete Form W-4P and give it to the payer as soon as possible. Get Pub. 505, Tax Withholding and Estimated Tax, to see how the dollar amount you are having withheld compares to your projected total federal income tax for 2012. You also may use the IRS Withholding Calculator at www.irs.gov/individuals for help in determining how many withholding allowances to claim on your Form W-4P.

Multiple pensions/more-than-one income. To figure the number of allowances that you may claim, combine allowances and income subject to withholding from all sources on one worksheet. You may file a Form W-4P with each pension payer, but do not claim the same allowances more than once. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4P for the highest source of income subject to withholding and zero allowances are claimed on the others.

Other income. If you have a large amount of income from other sources not subject to withholding (such as interest, dividends, or capital gains), consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Call 1-800-TAX-FORM (1-800-829-3676) to get Form 1040-ES and Pub. 505. You also can get forms and publications at www.irs.gov/formspubs.

If you have income from wages, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or Form W-4P.

Note. Social security and railroad retirement payments may be includible in income. See Form W-4V, Voluntary Withholding Request, for information on voluntary withholding from these payments.

Withholding From Pensions and Annuities

Generally, federal income tax withholding applies to the taxable part of payments made from pension, profit-sharing, stock bonus, annuity, and certain deferred compensation plans; from individual retirement arrangements (IRAs); and from commercial annuities. The method and rate of withholding depend on (a) the kind of payment you receive; (b) whether the payments are delivered outside the United States or its commonwealths and possessions; and (c) whether the recipient is a nonresident alien individual, a nonresident alien beneficiary, or a foreign estate. Qualified distributions from a Roth IRA are nontaxable and, therefore, not subject to withholding. See page 4 for special withholding rules that apply to payments outside the United States and payments to foreign persons.

Because your tax situation may change from year to year, you may want to refigure your withholding each year. You can change the amount to be withheld by using lines 2 and 3 of Form W-4P.

Choosing not to have income tax withheld. You (or in the event of death, your beneficiary or estate) can choose not to have federal income tax withheld from your payments by using line 1 of Form W-4P. For an estate, the election to have no income tax withheld may be made by the executor or personal representative of the decedent. Enter the estate's employer identification number (EIN) in the area reserved for "Your social security number" on Form W-4P.

You may not make this choice for eligible rollover distributions. See *Eligible rollover distribution—20% withholding* on page 4.

Caution. There are penalties for not paying enough federal income tax during the year, either through withholding or estimated tax payments. New retirees, especially, should see Pub. 505. It explains your estimated tax requirements and describes penalties in detail. You may be able to avoid quarterly estimated tax payments by having enough tax withheld from your pension or annuity using Form W-4P.

Periodic payments. Withholding from periodic payments of a pension or annuity is figured in the same manner as withholding from wages. Periodic payments are made in installments at regular intervals over a period of more than 1 year. They may be paid annually, quarterly, monthly, etc.

If you want federal income tax to be withheld, you must designate the number of withholding allowances on line 2 of Form W-4P and indicate your marital status by checking the appropriate box. Under current law, you cannot designate a specific dollar amount to be withheld. However, you can designate an additional amount to be withheld on line 3.

If you do not want any federal income tax withheld from your periodic payments, check the box on line 1 of Form W-4P and submit the form to your payer. However, see *Payments to Foreign Persons and Payments Outside the United States* on page 4.

Caution. If you do not submit Form W-4P to your payer, the payer must withhold on periodic payments as if you are married claiming three withholding allowances. Generally, this means that tax will be withheld if your pension or annuity is at least \$1,640 a month.

If you submit a Form W-4P that does not contain your correct social security number (SSN), the payer must withhold as if you are single claiming zero withholding allowances even if you checked the box on line 1 to have no federal income tax withheld.

There are some kinds of periodic payments for which you cannot use Form W-4P because they are already defined as wages subject to federal income tax withholding. These payments include retirement pay for service in the U.S. Armed Forces and payments from certain nonqualified deferred compensation plans and deferred compensation plans described in section 457 of tax-exempt organizations. Your payer should be able to tell you whether Form W-4P applies.

For periodic payments, your Form W-4P stays in effect until you change or revoke it. Your payer must notify you each year of your right to choose not to have federal income tax withheld (if permitted) or to change your choice.

Nonperiodic payments—10% withholding. Your payer must withhold at a flat 10% rate from nonperiodic payments (but see *Eligible rollover distribution—20% withholding* on page 4) **unless** you choose not to have federal income tax withheld. Distributions from an IRA that are payable on demand are treated as nonperiodic payments. You can choose not to have federal income tax withheld from a nonperiodic payment (if permitted) by submitting Form W-4P (containing your correct SSN) to your payer and checking the box on line 1. Generally, your choice not to have federal income tax withheld will apply to any later payment from the same plan. You cannot use line 2 for nonperiodic payments. But you may use line 3 to specify an additional amount that you want withheld.

Caution. If you submit a Form W-4P that does not contain your correct SSN, the payer cannot honor your request not to have income tax withheld and must withhold 10% of the payment for federal income tax.

Eligible rollover distribution—20% withholding. Distributions you receive from qualified pension or annuity plans (for example, 401(k) pension plans and section 457(b) plans maintained by a governmental employer) or tax-sheltered annuities that are eligible to be rolled over tax free to an IRA or qualified plan are subject to a flat 20% federal withholding rate. The 20% withholding rate is required, and you cannot choose not to have income tax withheld from eligible rollover distributions. Do not give Form W-4P to your payer unless you want an additional amount withheld. Then, complete line 3 of Form W-4P and submit the form to your payer.

Note. The payer will not withhold federal income tax if the entire distribution is transferred by the plan administrator in a direct rollover to a traditional IRA or another eligible retirement plan (if allowed by the plan), such as a qualified pension plan, governmental section 457(b) plan, section 403(b) contract, or tax-sheltered annuity.

Distributions that are (a) required by law, (b) one of a specified series of equal payments, or (c) qualifying “hardship” distributions are **not** “eligible rollover distributions” and are not subject to the mandatory 20% federal income tax withholding. See Pub. 505 for details. See also *Nonperiodic payments—10% withholding* on page 3.

Changing Your “No Withholding” Choice

Periodic payments. If you previously chose not to have federal income tax withheld and you now want withholding, complete another Form W-4P and submit it to your payer. If you want federal income tax withheld at the rate set by law (married with three allowances), write “Revoked” next to the checkbox on line 1 of the form. If you want tax withheld at any different rate, complete line 2 on the form.

Nonperiodic payments. If you previously chose not to have federal income tax withheld and you now want withholding, write “Revoked” next to the checkbox on line 1 and submit Form W-4P to your payer.

Payments to Foreign Persons and Payments Outside the United States

Unless you are a nonresident alien, withholding (in the manner described above) is required on any periodic or nonperiodic payments that are delivered to you outside the United States or its possessions. You cannot choose not to have federal income tax withheld on line 1 of Form W-4P. See Pub. 505 for details.

In the absence of a tax treaty exemption, nonresident aliens, nonresident alien beneficiaries, and foreign estates generally are subject to a 30% federal withholding tax under section 1441 on the taxable portion of a periodic or nonperiodic pension or annuity payment that is from U.S. sources. However, most tax treaties provide that private pensions and annuities are exempt from withholding and tax. Also, payments from certain pension plans are exempt from withholding even if no tax treaty applies. See Pub. 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*, and Pub. 519, *U.S. Tax Guide for Aliens*, for details. A foreign person should submit Form W-8BEN, *Certificate of Foreign Status of Beneficial Owner for United States Tax Withholding*, to the payer before receiving any payments. The Form W-8BEN must contain the foreign person’s taxpayer identification number (TIN).

Statement of Federal Income Tax Withheld From Your Pension or Annuity

By January 31 of next year, your payer will furnish a statement to you on Form 1099-R, *Distributions From Pensions, Annuities, Retirement or Profit-Sharing Plans, IRAs, Insurance Contracts, etc.*, showing the total amount of your pension or annuity payments and the total federal income tax withheld during the year. If you are a foreign person who has provided your payer with Form W-8BEN, your payer instead will furnish a statement to you on Form 1042-S, *Foreign Person’s U.S. Source Income Subject to Withholding*, by March 15 of next year.

Privacy Act and Paperwork Reduction Act Notice

We ask for the information on this form to carry out the Internal Revenue laws of the United States. You are required to provide this information only if you want to (a) request federal income tax withholding from periodic pension or annuity payments based on your withholding allowances and marital status, (b) request additional federal income tax withholding from your pension or annuity, (c) choose not to have federal income tax withheld, when permitted, or (d) change or revoke a previous Form W-4P. To do any of the aforementioned, you are required by sections 3405(e) and 6109 and their regulations to provide the information requested on this form. Failure to provide this information may result in inaccurate withholding on your payment(s). Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

**APPLICATION FOR REVERSE
 DEFERRED RETIREMENT OPTION PLAN**

DATE: ____/____/____

TO: LOCAL RETIREMENT BOARD

Having completed 24 or more years of credited service with the (employer name) _____,
 I, (name) _____, hereby submit my application for the REVERSE DROP under the
 terms of the Arizona Corrections Officer Retirement Plan. I am electing to participate in the REVERSE DROP and terminate
 employment on (date) ____/____/____, acknowledging that my effective date of retirement will be the first day of the
 month following my date of the election (A.R.S. Section 38-885.01(D)(1)). I am further designating as my REVERSE DROP
 date ____/____/____ (This date cannot exceed 60 months prior to my termination of employment or my completion of 24
 years of credited service) (A.R.S. Section 38-885.01(D)(1)). I understand that I will receive benefits from the system using the
 factors of credited service and average monthly benefit compensation in effect on the REVERSE DROP date (A.R.S. SECTION
 38-885.01(D)(3)).

ADDRESS: _____ HOME PHONE NUMBER: (____) ____ - _____

_____ WORK PHONE NUMBER: (____) ____ - _____

EMAIL: _____ CELL PHONE NUMBER: (____) ____ - _____

SPOUSE

Name: _____ Date of Birth: ____/____/____ Date of Marriage: ____/____/____

Social Security Number: ____ - ____ - _____

DEPENDENT CHILDREN

NAME	DATE OF BIRTH	IS CHILD DISABLED?		Is child 18-22 and in school fulltime?	
		YES	NO	YES	NO
_____	____/____/____	YES	NO	YES	NO
_____	____/____/____	YES	NO	YES	NO
_____	____/____/____	YES	NO	YES	NO
_____	____/____/____	YES	NO	YES	NO
_____	____/____/____	YES	NO	YES	NO

NOTE: Please provide a copy of:

1. Your Birth Certificate
2. Your Marriage Certificate
3. Your Spouse's Birth Certificate
4. Your Dependent Children's Birth Certificates
5. If Divorced during period of employment:
 - a. Photocopy of complete Divorce Decree, or
 - b. Certified Copy of Plan-Approved Domestic Relations Order
6. Medical Documentation for Disabled Children. (If applicable)

(NOTE: Please complete 2nd page)

APPLICATION FOR REVERSE DEFERRED RETIREMENT OPTION PLAN

FORM C4 RDROP

Page 2 of 2

Name of Member _____ S.S.N. _____ - _____ - _____ Date ____/____/____

1. LEAVE(S) WITHOUT PAY: During my period(s) of covered service, I have been on leave of absence without pay as indicated below:

- (a) None
(b) From ____/____/____ Through ____/____/____ Employer _____
From ____/____/____ Through ____/____/____ Employer _____
From ____/____/____ Through ____/____/____ Employer _____

2. INDUSTRIAL LEAVE: During my period(s) of covered service, I have received compensation benefits under the Worker's Compensation Laws of the State of Arizona as indicated below:

- (a) None
(b) From ____/____/____ Through ____/____/____ Employer _____
From ____/____/____ Through ____/____/____ Employer _____
From ____/____/____ Through ____/____/____ Employer _____

3. The information contained above is true, complete and correct to the best of my knowledge and belief. Further, I HEREBY AUTHORIZE the Local Board, the office of the board of trustees and/or their authorized designee to procure from my employer(s) or from any other person, firm or corporation (including any governmental agency or department thereof) any and all information as directly related to leave(s) of absence without pay and/or application(s) for and/or receipt of Worker's Compensation Benefits. I expressly waive all provision of law forbidding any doctor, person, firm or corporation (including any governmental agency or department thereof) from disclosing any knowledge or information which they have in their possession concerning leave(s) of absence without pay and/or Worker's Compensation. This is a limited release and is only to be in effect from this date to 120 days after first receipt of my retirement benefits.

By completing and signing this application, I hereby acknowledge receiving and reading the attached memorandum of understanding and agreement relating to the REVERSE DROP requirements.

WITNESS SIGNATURE MEMBER'S SIGNATURE

DATE: ____/____/____

EMPLOYER'S CERTIFICATION OF PARTICIPATION IN THE REVERSE DROP

The date that the member elected to participate in the REVERSE DROP and terminate employment is

____/____/____.

BY: _____ Signature and Title

REVERSE DROP BENEFICIARY DESIGNATION

PLEASE PRINT

I, _____, the undersigned, in the event of my death, direct that all amounts credited to my REVERSE deferred retirement option plan participation account shall be paid to:

Name of primary beneficiary / or Trust

Relationship: _____ Date of Birth: _____

If living, otherwise to: _____

Name(s) of contingent beneficiary(ies) / or Trust

Relationship: _____ Date of Birth: _____

if living, otherwise to my estate. It is agreed that if more than one primary or contingent beneficiary, as the case may be, is named, my said accumulated amounts, will be paid in equal shares to the survivors.

DATED IN _____, ARIZONA, ON THIS _____ DAY OF _____, 20____.

TO THE MEMBER AND SPOUSE:

Reverse DROP accumulated amounts are subject to the community property laws of this State. A member shall not make a beneficiary designation that results in an abrogation of a member's community property obligations. If you are married and designate someone other than your spouse, the CORP can only honor your election to the extent it complies with the Arizona community property laws. If you designate a primary refund beneficiary other than your spouse, by signing this form your spouse agrees to a spousal waiver of your REVERSE DROP accumulated amounts. This spousal waiver is only effective for your REVERSE DROP accumulated amounts.

WITNESS (Signature)

MEMBER (Signature)

WITNESS (Print Name)

MEMBER (Print Name)

(Witness must be other than beneficiaries named above)

Please complete and attach Form 9 if change of beneficiary reflects a marital status change which involves a name change of member.

STREET ADDRESS

CITY STATE ZIP

(____) _____ - _____
MEMBER TELEPHONE NUMBER

_____-_____-_____
SOCIAL SECURITY NUMBER

WITNESS (Signature)

SPOUSE (Signature)

WITNESS (Print Name)

SPOUSE (Print Name)

TO THE EMPLOYER:

Please forward to CORP
And retain a copy for your records.

EMPLOYER

**NOTIFICATION OF REVERSE
DROP BENEFITS AND ELECTION**

PAYABLE TO: _____
(Name of Member)

DATE FIRST REVERSE DROP BENEFIT CREDITED: _____ / ____ / ____ DATE LAST REVERSE DROP BENEFIT CREDITED: _____ / ____ / ____

TYPE OF BENEFIT: Reverse Deferred Retirement Option Plan

BENEFITS UNDER ARIZONA CORRECTIONS OFFICER RETIREMENT PLAN:

Monthly benefit credited to the REVERSE DROP account or monthly pension payable to member: \$ _____

The Local Retirement Board has met on _____ and determined that the applicant above is eligible for REVERSE DROP and the REVERSE DROP credit as shown above:
(date)

Name of Board

Signature of Board Chairman or Secretary

ELECTION AND ACCEPTANCE BY MEMBER

(Initial line below)

I ELECT TO ACCEPT the REVERSE Deferred Retirement Option Plan credit as determined under above, representing the REVERSE DROP benefits payable to me under the Corrections Officer Retirement Plan.

I UNDERSTAND that this election to receive REVERSE DROP credits pursuant to this document and under the CORP may not be revoked and is binding upon me or any beneficiary or survivor unless otherwise provided by law.

Date

Signature of Member

Signature of Witness

**REVERSE DEFERRED RETIREMENT OPTION PLAN
MEMORANDUM OF UNDERSTANDING AND AGREEMENT**

Your Statements to your employer and your CORP Local Board

Your employer and your Local Board will rely on the following facts. Each is important because it demonstrates you have carefully considered your election to participate in the REVERSE DROP.

Please initial each statement if true in the place shown in the left margin. If the statement is not true and **you do not initial each statement, you cannot enter into the REVERSE DROP.**

_____ I have received a copy of the REVERSE DROP law which sets forth the terms and conditions for participation in the REVERSE DROP.

_____ I have not been subject to any pressure, coercion, intimidation or threats by my employer or the Local Board or any of their agents in connection with my election to participate in the REVERSE DROP.

_____ I have had sufficient time to consider my options regarding my employment with my employer.

_____ I understand my decision to participate in the REVERSE DROP means I must retire and terminate my employment with my employer on the date I elect to participate in the REVERSE DROP.

_____ I understand there is a maximum period of sixty (60) consecutive months for participation in the REVERSE DROP, but in no case can my REVERSE DROP date predate my completion of twenty-four years of credited service.

_____ I understand that my years of service as of my REVERSE DROP date and my average monthly compensation as of my REVERSE DROP date will be the factors used in calculating all amounts credited to my REVERSE DROP account, as well my monthly pension.

_____ I understand that all contributions made pursuant to A.R.S. Section 38-891 during the period of the REVERSE DROP are not eligible to be refunded.

_____ I understand my decision to participate in the REVERSE DROP has very important consequences for me. I have been advised to consult an advisor such as an accountant or an attorney of my choosing if I have any questions about my participation in the REVERSE DROP.

_____ I understand this agreement has very important consequences for me and is legally binding on me. I have been advised to consult an attorney of my choosing if I have any questions about the agreement.

Your promises to your employer

Please initial each statement if true in the place shown in the left margin. If the statement is not true and you do not initial each statement, you cannot enter into the REVERSE DROP.

_____ I elect to participate in the REVERSE DROP.

_____ The number of months in my REVERSE DROP designation period is as prescribed in Form C4 RDROP. (The REVERSE DROP designation period may not exceed sixty (60) consecutive months or predate my completion of twenty-four years of credited service.)

_____ I will retire under the CORP and terminate my employment with my employer on the date I elect to participate in REVERSE DROP.

_____ I will abide by the terms and conditions of REVERSE DROP as prescribed by law.

**PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
CORRECTIONS OFFICER RETIREMENT PLAN
ELECTED OFFICIALS' RETIREMENT PLAN**
3010 East Camelback Road, Suite 200, Phoenix, Arizona 85016-4416
www.psprs.com

FORM U3 - Benefits
08/11
Page 1 of 2
P (602) 255-5575
F (602) 296-2369

LUMP SUM DISTRIBUTION ELECTION FORM FOR BENEFITS
(Note: If you are "refunding" your contributions, complete FORM U3 REFUNDS)

Name of Recipient: _____

SSN of Recipient: _____ Date of Retirement / Death: _____
(N/A for ex-spouse)

SECTION 1 - Distribution Type (check ONE)

DROP / DROP Beneficiary / CORP Reverse DROP OR Lump-Sum Death Benefit

SECTION 2 - Distribution Method (check ONE)

TOTAL Distribution to Recipient

The ENTIRE payment will be made to me less the applicable Federal withholding (generally 20%) based on the taxable portion of benefits. If this option is selected, sign below and return the original (you do not need to complete page 2 of 2.)

OR

Rollover

I elect to roll ALL or PORTION of the TAXABLE benefit to the financial institution(s) as indicated below.

If any portion is NON-TAXABLE, this amount cannot be rolled-over and will be mailed directly to you to the address on file. *Additionally, any amount not stated below will be mailed directly to you less the applicable Federal withholding (generally 20%) based on the taxable portion of benefits.*

List the Financial Institution(s) below and complete the <i>Agreement of Depository Trustee</i> , Page 2 of 2	Amount to Rollover
1)	\$
2)	\$
3)	\$
<input type="checkbox"/> If applicable, CHECK BOX to: Send BALANCE to me less the applicable Federal withholding (generally 20%).	

SECTION 3 – REQUIRED Signature Below

I authorize the release the appropriate funds in the manner identified above and I acknowledge that I have received a copy of the *Special Tax Notice*.

Signature (Member, Survivor/Beneficiary, or Ex-Spouse)

Date

Return form to your Local Board. (If ex-spouse, return to the PSPRS.)
Benefits will not be paid until the ORIGINAL document(s) are received.

AGREEMENT OF DEPOSITORY TRUSTEE

EACH financial institution MUST complete this page (make additional copies as needed)

In accordance with the authorization of the depositor on the corresponding *Lump Sum Distribution Election Form for Benefits*, we agree to deposit the forthcoming rollover amount in the following account:

Type of Account (check one):

- 1) Sec 401(a) Qualified Defined Benefit Plan
- 2) Sec 401(a) Qualified Defined Contribution Plan (Includes Sec 401k)
- 3) Sec 403(a) Qualified Annuity Plan
- 4) Sec 403(b) Tax Sheltered Annuity
- 5) Sec 408(a) Traditional IRA (Includes SEP IRA)
- 6) Sec 408(b) Individual Retirement Annuity
- 7) Sec 457 Governmental Plan

Name of Account Holder

Account Number

Name of Financial Institution

Signature of Financial Institution Representative

Date

Mailing Address

City

State

Zip

Return form to your Local Board. (If ex-spouse, return to the PSPRS.)
Benefits will not be paid until the ORIGINAL document(s) are received.

Mailing Address

City

State

Zip+4

AGREEMENT OF DEPOSITORY TRUSTEE

EACH financial institution MUST complete this page (make additional copies as needed)

In accordance with the authorization of the depositor on the corresponding *Lump Sum Distribution Election Form for Benefits*, we agree to deposit the forthcoming rollover amount in the following account:

Type of Account (check one):

- 1) Sec 401(a) Qualified Defined Benefit Plan Defined Benefit Plan
 2) Sec 401(a) Qualified Defined Contribution Plan (Includes Sec 401k)
 3) Sec 403(a) Qualified Annuity Plan
 4) Sec 403(b) Tax Sheltered Annuity
 5) Sec 408(a) Traditional IRA (Includes SEP IRA)
 6) Sec 408(b) Individual Retirement Annuity
 7) Sec 457 Governmental Plan

Name of Account Holder

Account Number

Name of Financial Institution

Signature of Financial Institution Representative

Date

Mailing Address

City

State

Zip

Return form to your Local Board. (If ex-spouse, return to the PSPRS.)
Benefits will not be paid until the ORIGINAL document(s) are received.

Mailing Address

City

State

Zip+4