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

MEMBERSHIP FORM

PLEASE PRINT INTERSYSTEM TRANSFER U2 TRANSFER

Name ______ Sex M F ______ Marital Status ______ Home Phone Number ( ) -

Social Security Number - - ______ Birth Date / / ______ Email Address ______

ADDRESS: ______
(Street) (Apt No.) (City) (State) (Zip)

Name of Spouse ______ Birth Date / / ______ Number of Children under 18 ______

1. Were you previously employed as a police officer **or** fire fighter in the State of Arizona?
   If yes, please fill in the following:

	FROM	THROUGH	TITLE OF POSITION	EMPLOYER
A.				
B.				

2. Was a refund issued? Circle **Y** or **N**
3. **A refund will NOT be issued while you are employed with the same/or another Public Safety employer.**

I declare under penalty of perjury that the above information is true, correct and complete, to the best of my knowledge and belief. (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 such System is guilty of a Class 6 felony. A.R.S. Section 38-849.B)

Date ______ Signature of Employee ______

EMPLOYER ACKNOWLEDGMENT

Membership Date (*with current employer*) / / ______ Employer ______

Position and Classification (Employee Must Work Full Time 40+ Hours Per Week To Be Eligible) ______ 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 by the member 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 System 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 ____________________, 20 _______.
(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: Public Safety Personnel Retirement System
3010 E. Camelback Rd., Suite 200
Phoenix, Arizona 85016

When Completed
Return to:

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

FORM P1A
08/11

APPLICATION TO TRANSFER SERVICE CREDITS BETWEEN PSPRS EMPLOYERS

(A.R.S. Section 38-853)

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: ______________________

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

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 38-849, SUBSECTION C (in part):
"...if such former member's reemployment with the same employer occurred within two years after termination date, and, **within ninety days after reemployment** the former member signs a written election consenting to reimburse the fund within one year, the former member shall be required to redeposit the amount withdrawn at the time of the former member's separation from service, with interest thereon at the rate of nine per cent for each year, compounded each year from the date of withdrawal to the date of repayment. Upon satisfaction of this obligation the member's prior service credits shall be reinstated." (emphasis added)

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.

____________________________ ____
Date Member Signature

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

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 __________________________

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

APPLICATION TO REDEEM PRIOR SERVICE WITHIN THE SAME RETIREMENT SYSTEM

(A.R.S. Section 38-853.01)

A.R.S. Section 38-853.01. Redemption of prior service

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

B. Any present active member who elects to redeem any part of the prior service for which the employee is deemed eligible by the board of trustees under this section shall pay into the system the amounts previously withdrawn by the member, if any, as a refund of the member's accumulated contributions plus accumulated interest as determined by the board of trustees and the additional amount, if any, computed by the system's actuary which 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 system's actuary.

PLEASE PRINT

1. ______________________ Member Name   ____-____-____ Social Security Number   ____/____/____ Date of Birth

   (____) ____-______ Telephone Number   ______________________ Email Address

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

2. ____
   Current Employer

   ____/____/____ Date of Hire   ______________________ Current Position/Title $__________ Current Annual Salary

3. ____
   Previous Employer(Employer during prior service)

   ____/____/____ Date of Hire   ______________________ Position/Title

   ____/____/____ Date of Termination   ______________________ Position/Title

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

   From _______/_______/_______ through _______/_______/_______ Total number of months: _________

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 PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM pursuant to A.R.S. Section 38-842.

Dated: _______/_______/_______   ______________________________________
Member's Signature

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016
(602)255-5575 FAX (602)255-5572 www.psprs.com

AFFIDAVIT TO REDEEM PRIOR RURAL METRO / CONTRACT SERVICE

(A.R.S. Section 38-853.01(A)(2)

A.R.S. Section 38-853.01(A)(2) Redemption of prior service

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

2. Subject to any limitations prescribed by federal law, prior employment as an employee with a corporation that contracted with an employer now covered by the system to provide firefighting services on behalf of that employer as a full-time paid firefighter or that provided firefighting services for a political subdivision of this state.

PLEASE PRINT

________________________ Member Name   ____-____-____ Social Security Number   ____/____/____ Date of Birth

( ) - ____________ Telephone Number   ________________ Address   City   State   Zip

________________________ Current Employer   ________________ Current Position/Title

________________________ Previous Employer ***WITH RURAL METRO***

____/____/____ Date of Hire | ____/____/____ Date of Termination

AMOUNT OF TIME I WANT CALCULATED: (Please Pick One)

________ ALL (✓) or ________# OF MONTHS or $______________ DOLLAR AMOUNT

Please *INITIAL* each of the following to indicate your agreement, otherwise this form will not be processed:

________ I have participated with a PSPRS employer for at least 5 years (if using 401a, 401k, 408a, 408b, or personal monies).

________ I was a full-time paid firefighter with Rural Metro.

________ I have not been credited with Rural Metro service in another plan.

________ I confirm that my service with Rural Metro was with an employer now participating in PSPRS.

________ I understand my purchase may be limited based upon the payment method I use.

The information in this application is true and correct to the best of my knowledge and pursuant to A.R.S. Section 38-853.01. I request that the board of trustees calculate the amounts required to be paid in order to receive Rural Metro time.

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.

This transaction is subject to audit.

Signature and Notary

Member Signature	Date

State of Arizona)
)
County of ______________________)

Subscribed and sworn (or affirmed) before me this ________ day of ____________________, 20____

(seal)

____
Notary Public

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
3010 E. Camelback Rd., Suite 200, PHOENIX, ARIZONA 85016
(602)255-5575 FAX (602)296-2368 www.psprs.com

APPLICATION FOR A SEPARATION REFUND OR DEFERRED ANNUITY

NAME: ______________________________ SOCIAL SECURITY NUMBER: ____________________
MAILING
ADDRESS: ____
(Street) (Apt. No.) (City) (State) (Zip)

PHONE NUMBER: ______________________ BIRTH DATE: ______________________

MY PSPRS MEMBERSHIP EMPLOYMENT WITH ______________________________

BEGAN ON ______________________ AND TERMINATED ON ______________________

I certify that I have terminated my employment; I have not been accepted for employ ment with any other PSPRS employer; I have not previously received a refund of myaccumulated contributions to the PSPRS; 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 apply for a refund of my accumulated contributions in the Arizona Public Safety Personnel Retirement System 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 PSPRS and myrights to rehearing and appeal. I also understand that withdrawing my accumulated REFUND contributions results inmy service credits in the PSPRS being cancelled. If I do not withdraw my contributions and I obtain employment with an employer in the PSPRS within two years after my termination, my service credits will be transferred to my record with my new employer. I understand that if I DO NOT withdraw my contributions and I DO NOT obtain employment with an employer in the PSPRS within two years after my termination, the termination of employment shall constitute a break in service, but I may be entitled to a deferred retirement benefit, see below; however, if I again obtain employment with an employer in the PSPRS my service shall be credited only from the date when my most recent re-employment period commences. If I withdraw my accumulated contributions and I am re-employed **by the same employer** within two years, I can have my service credits reinstated if, within 90 days of reemployment, I sign and file with my local PSPRS board a written election to reimburse the PSPRS and, within one year of reemployment, I repay to the PSPRS the accumulated contributions I withdrew, with interest as provided in A.R.S. § 38-849.C. If the refund includes taxable monies, I hereby acknowledge receiving and reading the special tax notice regarding these taxable monies. I further understand that pursuant to A.R.S. § 38-921, I may be entitled to transfer my service credits to a new state retirement system upon subsequent employment in a position not covered by PSPRS and that by withdrawing my contributions, I am forfeiting all of these rights. **If the Refund Option is selected, the refund check will be mailed to the address shown above within twenty (20) business days after this completed application, including the Employer's Certification of Termination, is filed with the BOARD OF TRUSTEES, PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM, 3010 E. Camelback Rd., Suite 200, PHOENIX, ARIZONA 85016, and the final wage deduction is sent to the Board of Trustees.**

DEFERRED ANNUITY OPTION

By INITIALING ________ this Deferred Annuity Option A.R.S. 38-846.01, 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 PSPRS. I also understand that if I die and I have accumulated contributions remaining in the PSPRS, 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 PSPRS 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 38-845, subsection F, or section 38-846, 38-856 or 38-857. **All changes of address must be reported, in writing, to the local PSPRS 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 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: ____________________ **FORM P6**

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 PSPRS to or on behalf of the applicant to arrive at refundable accumulated contributions. A.R.S. Sections 38-842.2 and 38-846.02)

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

If you have five or more years of <u>credited service</u> with the system 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. § 38-843, subsection C.
6 to 6.9—40% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-843, subsection C.
7 to 7.9—55% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-843, subsection C.
8 to 8.9—70% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-843, subsection C.
9 to 9.9—85% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-843, subsection C.
10 or more—100% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-843, subsection C, 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 **<u>do not</u>** count as credited service.

<u>LEAVES OF ABSENCE WITHOUT PAY</u> (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

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 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

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

APPLICATION FOR OPTION TO CONTRIBUTE DURING INDUSTRIAL LEAVE

A.R.S. Section 38-843 provides in part:

B. "...An employer shall have the option of paying a higher level percent of compensation thereby reducing its unfunded past service liability. An employer shall also have the option of increasing its contributions in order to reduce the contributions required from its members under subsection C, except that is an employer elects this option the employer shall pay the same higher level percentage contribution for all members of the eligible group. 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 shall make the contributions based on the compensation the employee would have received in his job classification if the employee was in normal employment status..."

C. "Each member, throughout the member's period of service from the member's effective date of participation, shall contribute to the fund an amount equal to the amount prescribed in subsection E, except as provided in subsection B. During a period when an employee is on industrial leave and the employee elects to continue contributions during the period of industrial leave, the employee shall make the employee's contribution 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 38-843, SUBSECTIONS B AND C,

PLEASE INITIAL ONE:

☐ Beginning _______/_______/_______, I ELECT TO CONTINUE

☐ I ELECT TO STOP

MAKING CONTRIBUTIONS TO THE PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM DURING MY PERIOD OF INDUSTRIAL LEAVE.

IF I ELECT TO CONTINUE MAKING CONTRIBUTIONS TO THE PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM 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 PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM 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: ______________________________

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

OUT OF STATE SERVICE AFFIDAVIT (Employee)

DO NOT ALTER THIS FORM OR USE WHITE OUT

Pursuant to A.R.S. 38-853.01, Each present active member of the system who has at least **TEN** years of service with the system may elect to redeem up to **SIXTY** months of any part of the following prior service or employment by paying into the system any amounts required under subsection B if the prior service or employment 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 this state or of a state of the United States as a full-time paid firefighter 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) ______ Telephone Number ( ) -

Former Employer or Retirement System Name ______ Position Held ______ Contact Person ______

Address (Street) (City) (State) (Zip) ______ Telephone Number ( ) -

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 PSPRS 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 PSPRS 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 PSPRS 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 certified peace officer or firefighter by the above employer during the dates listed.

_____ 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.

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 38-853.01.

______ 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

This form must be returned directly to Public Safety Personnel Retirement System

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

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 Public Safety Personnel Retirement System. 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) ________ Telephone Number ( ) -

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 firefighter 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 ________

This form must be returned directly to Public Safety Personnel Retirement System

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APPLICATION TO REDEEM TIME WITH AN ARIZONA PUBLIC SAFETY EMPLOYER PRIOR TO JOINDER DATE

(A.R.S. Section 38-853.01 Subsection A)

38-853.01 Redemption of prior service

A. Each present active member of the system who has at least **TEN** years of service with the system who had previous service in this state as an employee with an employer now covered by the system as a full-time paid firefighter 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 system 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 Board of Trustees calculate the amounts required to be paid in order to accomplish the requested redemption pursuant to A.R.S. 38-853.01.

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 reflects the data as contained in our records.

Please provide the full-time paid certified 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
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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.

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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 MUNCIPAL 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.

P (602) 255-5575

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
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www.psprs.com

F (602) 296-2368

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)

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

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

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016
(602)255-5575 FAX (602)296-2369 www.psprs.com

APPLICATION FOR DEFERRED RETIREMENT OPTION PLAN

TO: LOCAL RETIREMENT BOARD DATE: _______/_______/_______

Having completed 20 or more years of credited service with the (employer name) ___________________________________, I, (name) _____________________________________, hereby submit my application for the deferred retirement option plan (DROP) under the terms of the Arizona Public Safety Personnel Retirement System. I am electing to participate in the DROP on (date) _______/_______/_______, acknowledging that my effective date of participation in the DROP will be the first day of the month following my date of the election and that payments will be credited to my DROP account on or about the last day of the month following my DROP effective date (A.R.S. Section 38-844.03). I voluntarily and irrevocably designate a period of _______ months (can not exceed 60 months) as the period I wish to participate in the DROP. I understand that by participating in DROP, I must terminate employment with my employer on or before ______/_____/_____. I understand there are certain consequences if I do not terminate by this date.

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

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)
7. Proof of Full-time School Enrollment (If applicable)

(**NOTE:** Please complete 2nd page)

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 DROP requirements.

_________________________________ _________________________________

WITNESS SIGNATURE MEMBER'S SIGNATURE

DATE: _______/_______/______

EMPLOYER'S CERTIFICATION OF DROP DATE

The date that the member elected to participate in the DROP program is _______/_______/______.

After this date, employee and employer contributions will cease to be made to the PSPRS for members who had 20 years of credited service prior to 1/1/2012 (A.R.S. 38-844.06 (B). Employees who had less than 20 years of credited service on 1/1/2012 and elect to participate in DROP after 1/1/2012 shall make employee contributions to PSPRS in the same manner as an active employee who has not elected to participate in DROP pursuant to A.R.S. 38-843.

BY: _________________________________

Signature

____

Title

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 P8 DROP
8/11

Fax **OR** Mail form to:
Non-retired Fax
(602) 296-2368
Retired Fax
(602) 296-2369

Deferred Retirement Option Plan (DROP)

DROP 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	Member's Name (Last)	(First)	(Middle)
RETIREE SYSID (if known)	Date of Birth (MM/DD/YYYY)	Gender (Check One) ☐Male ☐Female	
Address – City, State, ZIP+4		E-mail Address	
Home Telephone # ( )	Cell # ( )	Work # ( )	

SECTION 2 – IMPORTANT DROP Beneficiary Information

- Pursuant to A.R.S. § 38-844.07, a member shall not make a beneficiary designation that results in an abrogation of a member's community property obligations under the applicable laws of this state. **If you are married and designate someone other than your spouse, by signing this form, your spouse agrees to a spousal waiver of your DROP accumulated amounts. This spousal waiver is only effective for your DROP accumulated benefit.**
- NOTE: Divorce automatically terminates the ex-spouse as the member's beneficiary. To maintain an ex-spouse as a beneficiary, you **must** complete a DROP Beneficiary Designation Form after the date of the divorce.

☒ **Primary**

SSN	Name of **DROP** Beneficiary (Last, First, Middle)	Relationship (check one) ☐Spouse ☐Child ☐Parent ☐Fiancé ☐Friend ☐Other
Birth Date (MM/DD/YYYY)	Address (City, State, ZIP+4)	Telephone # ( )

Check ONE ☐ Primary OR ☐ Secondary (If not checked, the following beneficiary is a primary beneficiary)

SSN	Name of **DROP** Beneficiary (Last, First, Middle)	Relationship (check one) ☐Spouse ☐Child ☐Parent ☐Fiancé ☐Friend ☐Other
Birth Date (MM/DD/YYYY)	Address (City, State, ZIP+4)	Telephone # ( )

Check ONE ☐ Primary OR ☐ Secondary (If not checked, the following beneficiary is a primary beneficiary)

SSN	Name of **DROP** Beneficiary (Last, First, Middle)	Relationship (check one) ☐Spouse ☐Child ☐Parent ☐Fiancé ☐Friend ☐Other
Birth Date (MM/DD/YYYY)	Address (City, State, ZIP+4)	Telephone # ( )

SECTION 3 – REQUIRED Signatures – If not previously provided and signature is a Power of Attorney (POA), provide our office with a copy of the POA .

PRINT Witness Name (cannot be beneficiary stated above)	Witness Signature	Date
Member's Signature		Date

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

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

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016
(602) 255-5575 FAX (602) 296-2369 www.psprs.com

NOTIFICATION OF DROP BENEFITS AND ELECTION

BEN TYPE: ____________

MEMBER'S NAME ______________________________

DATE FIRST DROP BENEFIT CREDITED: ___/___/___ DATE LAST DROP BENEFIT CREDITED: ___/___/___

PAYABLE TO: ______________________________
(Name of Member)

TYPE OF BENEFIT: Deferred Retirement Option Plan

BENEFITS UNDER ARIZONA PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM:

Monthly benefit credited to the DROP account or monthly pension payable to member: $ ____________

The Local Retirement Board has met on ____________ and determined that the applicant above is eligible for DROP and the DROP credit as shown above: (date)

______________________________ ______________________________
Name of Board Signature of Board Chairman or Secretary

ELECTION AND ACCEPTANCE BY MEMBER

(Initial)
____ I ELECT TO ACCEPT the Deferred Retirement Option Plan credit as determined above, representing the DROP benefits payable to me under the Public Safety Personnel Retirement System.

I UNDERSTAND that this election to receive DROP credits pursuant to this document and under the PSPRS 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

TO BE COMPLETED UPON TERMINATION OF EMPLOYMENT AT THE END OF THE DROP PERIOD

Member:
I am terminating employment and retiring on ___/___/___ acknowledging that the effective date of my retirement will be the first day of the following month with payments beginning on or about the last day of that month.

______________________________ Current Address: ______________________________
Signature ______________________________

Employer certification of termination date:

Member’s employment will terminate on: ___/___/___ Signature and title: ______________________________

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

Signature of Board Chairman or Secretary: ______________________________

DEFERRED RETIREMENT OPTION PLAN
MEMORANDUM OF UNDERSTANDING AND AGREEMENT

Your Statements to your employer and your PSPRS 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 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 DROP.

______ I have received a copy of the Arizona Revised Statutes as it relates to DROP, which sets forth the terms and conditions for participation in the 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 DROP.

______ I have had sufficient time to consider my options regarding my employment with my employer.

______ I understand my decision to participate in the DROP means I must retire and terminate my employment with my employer no later than the period of time I designate to participate in the DROP.

______ I further understand there is a maximum period of sixty (60) consecutive months for participation in the DROP.

______ I understand that during the DROP participation period I am not entitled to receive any health insurance subsidies or benefit increases from the PSPRS.

______ I understand that if my election to participate in DROP falls under the provisions of A.R.S. 38-844.06(B) , during the DROP participation period I will be required to make regular employee contributions to the System, but these contributions will not increase my credited service or be used to recalculate my monthly pension amount used to credit my DROP account.

______ I understand my decision to participate in the 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 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 DROP.

______ I elect to participate in the DROP.

______ The number of months in my DROP designation period is as prescribed in Form P4 DROP. (The DROP designation period may not exceed sixty (60) consecutive months. Interest accrues until the last day of the DROP period.)

______ I understand that my employer may have additional requirements and/or policies and procedures regarding mandatory termination of employment at the end of DROP. I have reviewed these policies and/or procedures with my employer.

______ I will retire under the PSPRS and terminate my employment with my employer no later than completion of my DROP participation period.

______ I understand that it is my responsibility to remember my DROP termination date. I understand that the Local Board, my employer or the Board of Trustees is not required to remind me of my DROP termination date.

_______I understand and agree that if I continue my employment with my employer as a member of a PSPRS eligible group beyond my DROP designated period the following will apply:

1. I will forfeit any interest accumulated on my DROP participation account.
2. I will not receive my lump sum DROP participation account amount until I actually terminate employment and retire from my employer.
3. If my election to participate in DROP falls within the provisions of 38-844.06 (A), I will not make any employee contributions to the PSPRS nor will my employer make any contributions to the PSPRS on my behalf and I will not accrue any credited service under the PSPRS.
4. If my election to participate in DROP falls within the provisions of 38-844.06 (B), I will make employee contributions to the PSPRS. Additionally, my employer will not make any contributions to the PSPRS on my behalf and I will not accrue any credited service under the PSPRS.
5. No further monthly payments will be credited to my DROP participation account.
6. I will begin directly receiving my monthly pension amount calculated at the beginning of my DROP period only when I terminate and retire with my employer. No retroactive monthly pension amounts will be made to me.

______ I will abide by the terms and conditions of DROP as prescribed by law.

Waiver

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 DROP.

______ I release my employer, the Local Board and the Board of Trustees from any and all claims based on my election to participate in the DROP and my agreement to retire and terminate my employment with my employer upon completion of my participation in the DROP.

______ I release my employer, the Local Board and the Board of Trustees from any and all claims under the Arizona and Federal Age Discrimination in Employment laws and Civil Rights laws as these laws relate to my participation in the DROP and my agreement to terminate employment with my employer upon the completion of my participation in the DROP.

______ I understand that the facts in respect of which this agreement is made and releases are given may hereafter turn out to be other than or different from the facts now known by me or believed by me to be true. I expressly accept and assume the risk of the facts turning out to be so different. I agree that any releases I make in this agreement shall be in all respects effective and not subject to termination or rescission by reason of any such differences in facts.

Covenant Not To Sue

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 DROP.

______ I will not sue my employer, the Local Board, the Board of Trustees, or their employees, officers and agents for any claim arising out of my election to participate in DROP, my participation in the DROP or my decision to retire and terminate employment with my employer upon the completion of my participation in DROP.

Your signature to the Agreement

______ I have carefully read this entire agreement.

______ I understand this agreement.

______ I am satisfied with this agreement.

______ I have signed my name voluntarily.

This is the only agreement I have made with my employer and the Local Board regarding my election to participate in the DROP, my employment with my employer during participation in the DROP and my agreement to terminate my employment with my employer and retire upon completing my participation in the DROP.

Dated: ____________________ ____________________________________
Member (Print)

____
Member (Signature)

____
Social Security Number

____
Employer Name

Dated: ____________________ BY: ____________________________________
Employer Signature

Dated: ____________________ BY: ____________________________________
Local Board Signature

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

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 *Agreement of Depository Trustee*, Page 2 of 2	Amount to Rollover
1)	$
2)	$
3)	$
☐ 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

Public Safety Personnel Retirement System
Retirement Instruction Manual

A manual of instructions, checklists and guidelines for completing a Deferred Retirement Option Plan (DROP), normal, or disability retirement in the Public Safety Personnel Retirement System.

DROP CHECKLIST 2
RETIRING FROM DROP CHECKLIST 5
NORMAL RETIREMENT CHECKLIST 10
DEFERRED ANNUITY CHECKLIST 15
SURVIVOR'S/GUARDIAN'S RETIREMENT CHECKLIST 18
DEATH BENEFICIARY CHECKLIST 24
DISABILITY RETIREMENT PROCESS OUTLINE 26
ACCIDENTAL DISABILITY PROCESS OUTLINE 33
TEMPORARY DISABILITY PROCESS OUTLINE 35
ORDINARY DISABILITY PROCESS OUTLINE 37
CATASTROPHIC DISABILITY CHECKLIST 39
STRESS DISABILITY LEGAL GUIDELINES 41
DUE PROCESS GUIDELINES FOR DISABILITY REHEARINGS 43
A GUIDE TO PROCESSING AN ACCIDENTAL, CATASTROPHIC OR ORDINARY DISABILITY RETIREMENT 45

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

DROP CHECKLIST

Forms and Documentation Required

Form P4 DROP
Form P8 DROP
Form P11
Form P12 DROP
Minutes from Local Board Approving DROP Participation
Memorandum of Understanding and Agreement
DROP Statutes (copy to employee and employer)

Copy of Member's Birth Certificate
If Married:
  Copy of Marriage Certificate
  Copy of Spouse's Birth Certificate
If Eligible Children:
  Copy of Children's Birth Certificates
If Divorced during period of employment:
  Photocopy of complete Divorce Decree or
  Certified copy of Plan-approved Domestic Relations Order
Medical Documentation for Disabled Children (If applicable)

* *

IMPORTANT DEADLINE

To ensure sufficient time for processing for timely payment of the DROP account, all applications must be received by the Board of Trustee's Administrative Office by the 10th of the month in which the DROP applicant will begin their DROP payment. For example, if a DROP applicant's election to enter the DROP is in July, their DROP becomes effective August 1st and their DROP 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 enter DROP packet in order for our office to make participation effective in our system.

* *

Form P4DROP - Application for DROP

Make sure this form is completely filled out, including necessary signatures. The date of election to participate in DROP on this form should agree with the ending service date on Form P11. The day after the election to participate date is the date when employer and employee contributions to the PSPRS stop. The member must have 20 years of credited service on the date of election to participate in order to be eligible to DROP. Any leaves without pay or industrial leaves should be noted and taken into consideration when computing credited service and the DROP benefit on Form P11. Remember that leaves without pay will affect one's credited service amount. The designated period to participate in DROP cannot exceed 60 months. Begin calculating the designated period to participate from the effective date of participation in DROP. For example, if a member elects to participate in DROP on August 2, 2001 and selects 6 months as their designated period, their effective date in DROP is September 1, 2001, their first payment will be credited on September 30, 2001 and he must terminate employment and retire on or before February 28, 2002. Assume he terminates employment February 14, 2002, their effective date of retirement will be March 1, 2002 and their first pension check and the DROP lump sum amount plus interest thru February will be paid to him on or about March 31, 2002.

The employer must be notified that the member is entering DROP. The local board needs to set up a chain of command to ensure that an official employer representative signs the bottom of the form. The date of election on the bottom of the form needs to be identical to the date prescribed at the top of the form.

Form P8DROP - Beneficiary Designation Form

This is a required document for DROP purposes under A.R.S. section 38-844.06.D. The law states that if the member dies during the DROP period, the designated beneficiary is entitled to receive the DROP account subject to the community property laws of this state. 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 be effective, only to the extent it complies with the Arizona Community Property Laws.

Form P11 - Benefit Calculations

Use this form for calculating the DROP pension amount. Be sure to verify the final contribution amount to PSPRS.

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 38-842.13:

> "...the member's total period of service before the member's effective date of participation, plus those compensated periods of the member's service thereafter for which the member made contributions to the fund."

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 DROP 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 PSPRS did not receive contributions must be noted on the Form P4DROP and should be subtracted from the member's total service to come up with the length of credited service.

A leave without pay, however, is considered "Service" under the PSPRS as long as it is an "absence which is authorized by an employer...(and) the employee returns within the period of authorized absence" (A.R.S Section 38-842.43). However, be careful because authorized leaves without pay that are a FULL pay period or more will not count towards the 20 year credited service requirement for a DROP.

Compensation: In calculating a retiree's average monthly compensation, the current PSPRS statute allows the member to use "three consecutive years within the last twenty completed years of credited service which yield the highest average". (A.R.S. Section 38-842.7)

These 3 years 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 compensation the employee would have received in this job classification if the employee was not on industrial leave". Be careful in determining the three consecutive years of compensation. If the member's last day of work was June 26, 2010, the beginning of the 3 year period ending on that date would be June 27, 2007, not June 26, 2007.

Make sure that you only include compensation that is permitted by the PSPRS statute. A.R.S. Section 38-842.12, defines the allowable compensation as follows:

"Compensation" means, for the purpose of computing retirement benefits, base salary, overtime pay, shift differential pay, military differential wage pay, compensatory time used by an employee in lieu of overtime not otherwise paid by an employer and holiday pay paid to an employee by the employer on a regular monthly, semimonthly or biweekly payroll basis and longevity pay paid to an employee at least every six months for which contributions are made to the system pursuant to Section 38-843, subsection D. Compensation does not include, for the purpose of computing retirement benefits, payment for unused sick leave, payment in lieu of vacation, payment for unused compensatory time or payment for any fringe benefits. In addition, compensation does not include, for the purposes of computing retirement benefits, payments made directly or indirectly by the employer to the employee for work performed for a third party on a contracted basis or any other type of agreement under which the third party pays or reimburses the employer for the work performed by the employee for that third party, except for the third party contracts between public agencies for law enforcement, criminal, traffic and crime suppression activities training, or fire, wildfire emergency medical or emergency management activities or where the employer supervises the employee's performance of law enforcement, criminal, traffic and crime suppression activities, training or fire, wildfire, emergency medical or emergency management services. For the purposes of the paragraph, "base salary" means the amount of compensation each employee is regularly paid for personal services rendered to an employer before the addition of any extra monies, including overtime pay, shift differential pay, holiday pay, longevity pay, fringe benefit pay and similar extra payments.

Benefit Calculations: Make sure that you use the correct section of Form P11 to calculate the appropriate benefit calculation for each particular DROP applicant.

For retirement with 20 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 P11 and a new Form P12DROP with the member's signature must be submitted before the first DROP payment can be credited to the DROP applicant.

Form P12DROP - Notification of Benefits and Election

The "Date First DROP Benefit Credited" should be the last day of the next calendar month following the member's election to participate in the DROP. For example, if the member's election into the DROP were on December 23, 2000, the "Date First Benefit Credited" would be January 31, 2001.

Make sure the 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.

Make sure you calculate the correct "Date Last DROP Benefit Credited" based upon the member's election to participate in DROP on form P4DROP. The day should be the last day of the calendar month of the member's designated DROP period. For instance, if a member elects to participate in DROP on June 2, 2001 and selects 6 months as his designated period, his effective date in DROP is July 1, 2001, his first payment will be credited on July 31, 2001 and he must terminate employment and retire on or before December 31, 2001. The date last DROP benefit credited would be December 31, 2001. Note that this amount will be paid on the last business day of the following month.

Mail the original P12DROP to the board of trustees and keep a copy for your records. Use your copy once member is ready to exit DROP and terminate employment. Prior to the end of his DROP period the member will come to the Local Board and complete the bottom portion of this form. The member's signature and the signature of both the employer and the local board chairman authorizes us to begin the monthly pension payment as well as disbursing the DROP monies. Once the signatures are completed, make a copy for your records and mail the board of trustees the "hybrid" original.

Local Board Minutes Approving Deferred Retirement Option

The Local Board's initial authorization to the Administrative Office to begin DROP payments is on Form P12DROP - 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 DROP and DROP credits as shown above." This gives us the authority to begin the applicant's initial DROP credit. Similarly, when the member terminates employment and retires, the Local Board's authorization on the bottom of this form will allow us to begin disbursing the DROP monies as well as begin monthly pension payments.

A.R.S. Section 38-847.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" and 38-847.H requires that the decisions to be sent via certified mail.

In addition A.R.S. Section 38-847.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 and all necessary communications as prescribed by subsection G of this section."

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 DROP laws to the employee and the employer. This is important for the employer, as they need to adjust their payroll records to terminate employer and employee contributions to the PSPRS.

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

RETIRING FROM DROP CHECKLIST

Forms and Documentation

Form 8 (Optional)
P12DROP
Form 13
Form U3 Benefits Lump Sum Distribution Election
Special Tax Notice (copy to retiree)
Federal Tax Withholding Preference Certificate Form W-4P
State Tax Withholding Preference Certificate Form A-4P
Minutes from Local Board Approving Retirement

If not previously submitted with DROP application:
Copy of Member's Birth Certificate
If Married:
Copy of Marriage Certificate
Copy of Spouse's Birth Certificate
If Eligible Children:
Copy of Children's Birth Certificates
If Divorced during period of employment:
Photocopy of complete Divorce Decree or
Certified copy of Plan-approved Domestic Relations Order
Medical Documentation for Disabled Children (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 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 retiring from DROP packet in order for our office to make retirement effective in our system.

* *

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.

Form P12DROP - Notification of DROP Benefits and Election

Your office should have a copy of form P12DROP, which was filled out when the member entered the DROP. Make another copy and fill out the bottom portion entitled "To Be Completed upon Termination of Employment at the End of the Drop Period."

Form 13 - Authorization To Start or Cancel Direct Deposit

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 P12DROP. 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, 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 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 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.

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.

Personal Documents not Previously Submitted

If any applicable birth certificates or other documents were not sent to this office, please forward those at this time.

Local Board Minutes Approving Retirement

The Local Board's initial authorization to the Administrative Office to pay retirement benefits is on Form P12DROP - Notification of DROP 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 payments as shown above." This gives us the authority to issue the retiree's initial retirement benefit.

A.R.S. Section 38-847.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" and 38-847.H requires that the decisions to be sent via certified mail.

In addition, A.R.S. Section 38-847.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 and all necessary communications as prescribed by Subsection G of this section."

An example of minutes noted for a DROP participant who is retiring could read as follows:

"[*Member Name*] has elected to term their participation in the DROP Program on June 30, 2011, and apply for Normal/Accidental/Disability Retirement."

Please include the monthly pension amount as a part of the local board minutes.

Health Insurance Plans and Subsidy Available to Retirees

Retiring Public Safety Personnel Retirement System (PSPRS) 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 PSPRS 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.

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

NORMAL RETIREMENT CHECKLIST

Forms and Documentation Required

Form P4
Form 8 (Optional)
Form P11
Form P12
Form 13
Federal Tax Withholding Preference Certificate Form W-4P
State Tax Withholding Preference Certificate Form A-4P
Minutes from Local Board Approving Retirement

Copy of Member's Birth Certificate
If Married:
 Copy of Marriage Certificate
 Copy of Spouse's Birth Certificate
If Eligible Children:
 Copy of Children's Birth Certificates
If Divorced during period of employment:
 Photocopy of complete Divorce Decree or
 Certified copy of Plan-approved Domestic Relations Order
Medical Documentation for Disabled Children (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 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 retirement effective in our system.

* *

Form P4 - 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 ending service date on Form P11. Any leaves without pay or industrial leaves should be noted and taken into consideration when computing credited service and the retirement benefit on Form P11.

Form 8 – Beneficiary Designation Form (Optional)

Retirement is a good time for members to update their beneficiary information. Many members are surprised to find who we have listed as their beneficiaries at the time of retirement (ex-spouses, deceased parents, etc.), so we would encourage retirees to submit this form along with their retirement applications.

Form P11 - Benefit Calculations

Use this document for calculating Normal Service Retirements. Be sure to verify and note the final contribution amount to PSPRS on this form.

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 38-842.13:

> "...the member's total period of service before the member's effective date of participation, plus those compensated periods of the member's service thereafter for which the member made contributions to the fund."

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 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 PSPRS did not receive contributions must be noted on the Form P4 and should be subtracted from the member's total service to come up with the length of credited service.

A leave without pay, however, is considered "Service" under the PSPRS as long as it is an "absence which is authorized by an employer...(and) the employee returns within the period of authorized absence" (A.R.S Section 38-842.43). Authorized leaves without pay that are a FULL pay period or more will count toward the 20 year service requirement for a Normal Retirement, but may result in a member having less than 20 years of credited service.

Compensation: In calculating a retiree's average monthly compensation, the current PSPRS statute allows the member to use "three consecutive years within the last twenty completed years of credited service which yield the highest average". (A.R.S. Section 38-842.7)

These 3 years 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 compensation the employee would have received in this job classification if the employee was not on industrial leave". Be careful in determining the three consecutive years of compensation. If the member's last day of work was June 26, 2010, the beginning of the 3 year period ending on that date would be June 27, 2007, not June 26, 2007.

Make sure that you only include compensation that is permitted by the PSPRS statute. A.R.S. Section 38-842.12, defines the allowable compensation as follows:

"Compensation" means, for the purpose of computing retirement benefits, base salary, overtime pay, shift differential pay, military differential wage pay, compensatory time used by an employee in lieu of overtime not otherwise paid by an employer and holiday pay paid to an employee by the employer on a regular monthly, semimonthly or biweekly payroll basis and longevity pay paid to an employee at least every six months for which contributions are made to the system pursuant to Section 38-843, subsection D. Compensation does not include, for the purpose of computing retirement benefits, payment for unused sick leave, payment in lieu of vacation, payment for unused compensatory time or payment for any fringe benefits. In addition, compensation does not include, for the purposes of computing retirement benefits, payments made directly or indirectly by the employer to the employee for work performed for a third party on a contracted basis or any other type of agreement under which the third party pays or reimburses the employer for the work performed by the employee for that third party, except for the third party contracts between public agencies for law enforcement, criminal, traffic and crime suppression activities training, or fire, wildfire emergency medical or emergency management activities or where the employer supervises the employee's performance of law enforcement, criminal, traffic and crime suppression activities, training or fire, wildfire, emergency medical or emergency management services. For the purposes of the paragraph, "base salary" means the amount of compensation each employee is regularly paid for personal services rendered to an employer before the addition of any extra monies, including overtime pay, shift differential pay, holiday pay, longevity pay, fringe benefit pay and similar extra payments.

Benefit Calculations: Make sure that you use the correct section of Form P11 to calculate the appropriate benefit calculation for each particular retiree.

For retirement with 20 years of credited service but less than 25 years of credited service: Use Section D.

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

For retirement with 20 or more years of service, but less than 20 years of credited service: Use Section F.

If benefit calculations are incorrect when submitted, a corrected Form P11 and a new Form P12 with the member's signature must be submitted before the first benefit check can be released to the retiree.

Form P12 - 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, 2008, the "Date First Payment Due" should be January 31, 2009. Please note that the board shall not make a retroactive payment of a pension to a person that is more than ninety days before the date of the person's application for benefits (A.R.S. Section 38-845.02)

Make sure the retiree, applicant or 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 Start or Cancel Direct Deposit

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 P4. 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 bank 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, 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 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 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.

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 Administrative Office to pay retirement benefits is on Form P12 - 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 payments as shown above." This gives us the authority to issue the retiree's initial retirement benefit.

A.R.S. Section 38-847.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" and 38-847.H requires that the decisions to be sent via certified mail.

In addition A.R.S. Section 38-847.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 and all necessary communications as prescribed by subsection G of this section."

Health Insurance Plans and Subsidy Available to Retirees

Retiring Public Safety Personnel Retirement System (PSPRS) 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 PSPRS 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.

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

DEFERRED ANNUITY CHECKLIST

Forms and Documentation Required

Form P4D
Form 8
Deferred Annuity Calculation
Form P12
Form 13
Federal Tax Withholding Preference Certificate Form W-4P
State Tax Withholding Preference Certificate Form A-4P
Minutes from Local Board Approving Annuity

Copy of Applicant's Birth Certificate
If Married:
  Copy of Marriage Certificate
  Copy of Spouse's Birth Certificate
If Eligible Children:
  Copy of Children's Birth Certificates
If Divorced during period of employment:
  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 P4D - Application for Deferred Annuity

Make sure the application is completely filled out, including necessary signatures. Any leave without pay or industrial leave should be noted on page 2. Attach copies of the supporting documentation as required on the P4D.

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 spreadsheet **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 PSPRS Employer menu and by selecting "Spreadsheets". Select the "Retirement Forms" spreadsheet and fill in the Input Sheet with the required data.

Any 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 PSPRS 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 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 PSPRS did not receive contributions must be noted on the Form P4D and should be subtracted from the member's total service to come up with the length of credited service.

Form P12 - 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. Please note that the board shall not make a retroactive payment of a pension to a person that is more than ninety days before the date of the person's application for benefits (A.R.S. Section 38-845.02)

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 Start or Cancel Direct Deposit

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 P4D. 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, 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:

Line 1 - No federal withholding will be deducted from the benefit check.
Line 2 - Federal withholding based on the applicant'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 applicant'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 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.

Annuitant's 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 Administrative Office to pay annuity benefits is on Form P12 - 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 annuity benefit payments as shown above." This gives us the authority to issue the applicant's initial annuity benefit.

A.R.S. Section 38-847.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" and 38-847.H requires that the decisions to be sent via certified mail.

In addition A.R.S. Section 38-847.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 and all necessary communications 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 section 38-845, subsection F, or section 38-846, 38-856, 38-856.02 or 38-857.

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

SURVIVOR'S/GUARDIAN'S RETIREMENT CHECKLIST

Forms and Documentation Required

Form P7S
Form 8 (Optional)
Form P11
Form P12
Form 13
Federal Tax Withholding Preference Certificate Form W-4P
State Tax Withholding Preference Certificate Form A-4P
Minutes from Local Board Approving Survivor's
Retirement and Terminating Member's Pension

Copy of Member's Death Certificate
Copy of Survivor's/Guardian's Birth Certificate
Copy of Marriage Certificate (if applicable)
Copy of Survivor's/Guardian's Social Security Card
If Eligible Children:
Copy of Children's Birth Certificates
Medical Documentation for Disabled Children (If applicable)
Proof of Fulltime 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 pension becomes effective August 1st and the survivor/guardian 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.

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Form P7 - Application for a Survivor's Benefit

Make sure this form is completely filled out, including the necessary signatures and verification of receipt by the employer. The applicant must indicate the type of Survivor's Benefit they are applying for and complete the appropriate sections on this form.

SURVIVING SPOUSE: The PSPRS statue 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 on the date 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 consecutive years at the time of the member's death.

The State of Arizona does not recognize common law marriages and neither will the PSPRS. 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 OF DECEASED MEMBER'S ELIGIBLE CHILDREN: The applicant must be the legal guardian of the deceased member's "Eligible Child" as defined in A.R.S. Section 38-842.23:

"Eligible Child" means an unmarried child of a deceased member or retired member who meets one of the following qualifications:
(a) Is under the age of 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 a 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 deceased member or legally adopted. The applicant must supply proof of adoption.

A guardian's pension is payable only if there is no eligible surviving spouse receiving Survivor's Benefits and only until the youngest eligible child reaches age 23.

If there is an eligible Surviving Spouse and also a separate guardian for the deceased member's eligible children, both will need to complete a separate Form 7 - Application for a Survivor's Benefit and the applications will be processed independently. In such case, the guardian will be entitled to only the applicable child's portion of the survivor's benefit as long as a surviving spouse's pension is being paid.

Form P11 - Benefit Calculations

FOR DECEASED RETIRED MEMBERS WHO WERE RECEIVING NORMAL SERVICE RETIREMENT BENEFITS AT THE TIME OF DEATH, Use this form for calculating Surviving Spouse, Guardian and Eligible Child Benefits.

For deceased members already receiving normal service retirement benefits, you will not need to recalculate the member's pension. Complete the top section of the P11 giving the identification and service information on the deceased member and indicate the deceased member's monthly benefit at the time of death on the appropriate line, Line D3, E3 or F3. The Surviving Spouse or Guardian pension is calculated on Line G and the Eligible Child pension is calculated on Line H.

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 RETIRED MEMBERS WHO WERE RECEIVING DISABILITY RETIREMENT BENEFITS AT THE TIME OF DEATH, Use the P11D form for calculating Surviving Spouse, Guardian and Eligible Child Benefits.

Complete the top section of the P11D giving the identification and service information on the deceased member and indicate the deceased member's monthly disability at the time of death on the appropriate line, either Line D1 or D2. The Surviving Spouse or Guardian pension is calculated on Line H and the Eligible Child pension is calculated on Line I.

FOR DECEASED ACTIVE (NON-RETIRED) MEMBERS, Use the P11D form for calculating Surviving Spouse, Guardian and Eligible Child Benefits. Pursuant to A.R.S. Section 38-846, the surviving spouse of a deceased active member shall receive a monthly benefit computed as for the surviving spouse of a member under the assumption that the member had retired by reason of accidental disability immediately before death.

For deceased active members with less than 20 years of Credited Service, you will need to do the 3-year compensation (Section A through C) and compute the monthly benefit on Line D1. The Surviving Spouse and Guardian pension is calculated on Line H and the Eligible Child pension is calculated on Line I.

For deceased active members with 20 or more years of Credited Service, you will need to do a normal service retirement calculation on the P11 form and transfer it over to Line D2 on the P11D and proceed with the survivor calculations on Lines H and I.

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 PSPRS.

If benefit calculations are incorrect when submitted, a corrected Form P11D and a new Form P12 with the survivor's or guardian's signature must be submitted before the first benefit check can be released to the survivor or guardian.

Form P12 - Notification of Benefits and Election

The PSPRS member's name should go in the space requesting the "Member's Name" with the Surviving Spouse or Guardian's name listed on the line requesting "Payable to".

Make sure that you mark the Type of Benefit: Survivor or Guardian.

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, 1988, the "Date First Payment Due" should be January 31, 1989. Please note that the board shall not make a retroactive payment of a pension to a person that is more than ninety days before the date of the person’s application for benefits (A.R.S. Section 38-845.02)

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 Start or Cancel Direct Deposit

A survivor'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 P7. 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.

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 survivor 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 PSPRS retirement benefits in excess of $2500 annually effective retroactive to tax year commencing January 1, 1989.

The survivor 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.

Survivor's 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

MAKE SURE YOUR LOCAL BOARD VOTES TO TERMINATE THE DECEASED MEMBER'S BENEFIT AS WELL AS APPROVE THE SURVIVOR BENEFITS. The Local Board's initial authorization to the Administrative Office to pay retirement benefits is on Form P12 - 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 payments as shown above." This gives us the authority to issue the survivor's initial retirement benefit.

A.R.S. Section 38-847.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" and 38-847.H requires that the decisions to be sent via certified mail.

In addition A.R.S. Section 38-847.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 and all necessary communications as prescribed by subsection G of this section."

Health Insurance Plans and Subsidy Available to Retirees

Retiring Public Safety Personnel Retirement System (PSPRS) 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 PSPRS 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)

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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.

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

DEATH BENEFICIARY CHECKLIST

Forms and Documentation Required

Form P7D
Form 13
Federal Tax Withholding Preference Certificate Form W-4P
State Tax Withholding Preference Certificate Form A-4P
Form U3 Benefits Lump Sum Distribution Election
Special Tax Notice (copy to Beneficiary)
Minutes from Local Board Approving Death Benefit

Copy of Member's Death Certificate
Certified Personal Representative letter (if applicable)
Copy of Designated Beneficiary's Driver's License
Copy of Designated Beneficiary's Social Security Card

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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.

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Form P7D- Application for a Death Benefit (A.R.S. 38-846.I)

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, Designated Beneficiary.

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

Form 13 - Authorization To Start or Cancel Direct Deposit

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 the Appendix A page 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 verifying a Designated Beneficiary's eligibility and approval for payment to PSPRS as prescribed in A.R.S. Section 38-847.M.

A.R.S. Section 38-847.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" and 38-847.H requires that the decisions to be sent via certified mail.

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

DISABILITY RETIREMENT CHECKLIST

Forms and Documentation Required

Form P5-EE
Form P5-LB
Form P5-LB-A, O, C, or T (as applicable)
Form 8 (Optional)
Form P11D
Form P12
Form 13
Federal Tax Withholding Preference Certificate Form W-4P
State Tax Withholding Preference Certificate Form A-4P
Minutes from Local Board Approving Retirement
Medical Reports and Documentation Supporting Award of Disability

Copy of Member's Birth Certificate
If Married:
Copy of Marriage Certificate
Copy of Spouse's Birth Certificate
If Eligible Children:
Copy of Children's Birth Certificates
If Divorced during period of employment:
Photocopy of complete Divorce Decree or
Certified copy of Plan-approved Domestic Relations Order
Medical Documentation for Disabled Children (If applicable)

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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 member'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.

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Form P5-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. Per 38-847(D)(3):

> "To make a determination as to the right of any claimant to a benefit and to afford any claimant or the board of trustees, or both, a right to a rehearing on the original determination. Unless all parties involved in a matter presented to the local board for determination otherwise agree, **the local board shall commence a hearing on the matter within ninety days after the date the matter is presented to the local board for determination**. If a local board fails to commence a hearing as provided in this paragraph, on a matter presented to the local board for determination, the relief demanded by the party petitioning the local board is deemed granted and approved by the local board. The granting and approval of this relief is considered final and binding unless a timely request for rehearing or appeal is made as provided in this article, unless the board of trustees determines that granting the relief requested would violate the internal revenue code or threaten to impair the system's status as a qualified plan under the internal revenue code. If the board of trustees determines that granting the requested relief would violate the internal revenue code or threaten to impair the system's status as a qualified plan, the board of trustees may refuse to grant the relief by issuing a written determination to the local board and the party petitioning the local board for relief. The decision by the board of trustees is subject to judicial review pursuant to title 12, chapter 7, article 6."

The ninety days starts with the date the local board receives the application.

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 the member from further employment with the PSPRS employer.

The applicant must designate the Type of Disability they are applying for:

An ORDINARY DISABILITY is a non-job-related physical condition which totally and permanently prevents the applicant from performing a reasonable range of duties within their department or a non-job-related mental condition which totally and permanently prevents the applicant from engaging in any substantial gainful activity.

An ACCIDENTAL DISABILITY is a job-related physical or mental condition which totally and permanently prevents the applicant from performing a reasonable range of duties within their job classification.

A TEMPORARY DISABILITY is a job-related physical or mental condition which totally and temporarily prevents the applicant from performing a reasonable range of duties within their department.

A CATASTROPHIC DISABILITY is a job-related physical and not a psychological condition that is not an accidental disability which totally and permanently prevents the applicant from engaging in any gainful employment.

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/her 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 at the top of page two 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 P5-LB – Local Board Determination For Disability Retirement

The Local Board will need to print and complete the disability questionnaire that is selected on the P5-EE 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 P5-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, catastrophic, or ordinary disability pension shall commence as of the first day of the month following the date of retirement or the expiration of a period during which the member is receiving sick leave payments or a temporary disability pension, whichever is later." (38-844.B, C & I.) Pursuant to A.R.S. 38-845.02, "The Board shall not make a retroactive payment of a pension of a person that is more than ninety days before the date of the person's application for benefits."'

The Local Board must then forward to the Board of Trustees' office, the original P5-EE and required documents, P5-LB, Disability Questionnaire, a copy of the IME, and the Local Board meeting minutes sent via certified mail pursuant to A.R.S. 38-847.G.

Form P5-LB-A, P5-LB-T, P5-LB-C, or P5-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 good time for members to update their beneficiary information. Many members are surprised to find who we have listed as their beneficiaries at the time of retirement (ex-spouses, deceased parents, etc.), so we would encourage retirees to submit this form along with their retirement applications.

Form P11D – Disability Benefit Calculations

Use this form for calculating Disability Retirements. Be sure to verify and note the final contribution amount to PSPRS on this form.

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 38-842.13:

> "...the member's total period of service before the member's effective date of participation, plus those compensated periods of the member's service thereafter for which the member made contributions to the fund."

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 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 PSPRS did not receive contributions must be noted on the Form P11D and should be subtracted from the member's total service to come up with the length of credited service.

A leave without pay, however, is considered "Service" under the PSPRS as long as it is an "absence which is authorized by an employer...(and) the employee returns within the period of authorized absence" (A.R.S Section 38-842.43).

Compensation: Make sure that you only include compensation that is permitted by the PSPRS statute. A.R.S. Section 38-842.12, defines the allowable compensation as follows:

"Compensation" means, for the purpose of computing retirement benefits, base salary, overtime pay, shift differential pay, military differential wage pay, compensatory time used by an employee in lieu of overtime not otherwise paid by an employer and holiday pay paid to an employee by the employer on a regular monthly, semimonthly or biweekly payroll basis and longevity pay paid to an employee at least every six months for which contributions are made to the system pursuant to Section 38-843, subsection D. Compensation does not include, for the purpose of computing retirement benefits, payment for unused sick leave, payment in lieu of vacation, payment for unused compensatory time or payment for any fringe benefits. In addition, compensation does not include, for the purposes of computing retirement benefits, payments made directly or indirectly by the employer to the employee for work performed for a third party on a contracted basis or any other type of agreement under which the third party pays or reimburses the employer for the work performed by the employee for that third party, except for the third party contracts between public agencies for law enforcement, criminal, traffic and crime suppression activities training, or fire, wildfire emergency medical or emergency management activities or where the employer supervises the employee's performance of law enforcement, criminal, traffic and crime suppression activities, training or fire, wildfire, emergency medical or emergency management services. For the purposes of the paragraph, "base salary" means the amount of compensation each employee is regularly paid for personal services rendered to an employer before the addition of any extra monies, including overtime pay, shift differential pay, holiday pay, longevity pay, fringe benefit pay and similar extra payments.

For calculating the benefit for an ACCIDENTAL, CATASTROPHIC or ORDINARY Disability, the current PSPRS statute allows the member to use "three consecutive years within the last twenty completed years of credited service which yield the highest average". (A.R.S. Section 38-842.7)

These 3 years **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 compensation the employee would have received in his job classification if the employee was not on industrial leave". Be careful in determining the three consecutive years of compensation. If the member's last day of work was June 26, 1989, the beginning of the 3 year period ending on that date would be June 27, 1986, not June 26, 1986.

For calculating the benefit for a TEMPORARY Disability, you will only need to calculate the one year of compensation received by the member immediately prior to the date on which his disability was incurred. DO NOT USE THE 3-YEAR AVERAGING DESCRIBED ABOVE. Just put one year of compensation on the lines provided in Section A of Form P11D.

Benefit Calculations: Make sure that you use the correct section on the Form P11D to calculate the appropriate benefit calculation for each particular retiree.

For Ordinary Disability Retirement: Use Section F.

For Accidental Disability Retirement: Use Section D.

For Temporary Disability Retirement: Use Section E.

For Catastrophic Disability Retirement: Use Section G.

If benefit calculations are incorrect when submitted, a corrected Form P11D and a new Form P12 with the members' signature must be submitted before the first benefit check can be released to the retiree.

Form P12 - Notification of Benefits and Election

Make sure that you mark the Type of Benefit: Ordinary Disability, Accidental Disability, Catastrophic Disability or Temporary Disability.

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 December 23, 1988, the "Date First Payment Due" should be January 31, 1989. Please note that the board shall not make a retroactive payment of a pension to a person that is more than ninety days before the date of the person's application for benefits (A.R.S. Section 38-845.02)

Make sure the retiree 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 Start or Cancel Direct Deposit

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 P5. 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 bank 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 PSPRS are tax-exempt at the federal level for disability retirees who retire with less than 20 years of credited service (Accidental and Temporary) or less than 25 years of credited service (Catastrophic). However, Accidental and Temporary Disability retirees with more than 20 years of credited service, Catastrophic Disability retirees with more than 25 years of credited service, and those retired under a non-job-related Ordinary Disability will be taxed on their retirement benefits at the federal level.

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.

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 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.

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 Administrative Office to pay disability retirement benefits is on Form P12 - 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 payments as shown above." This gives us the authority to issue the retiree's initial disability retirement benefit.

A.R.S. Section 38-847.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" and 38-847.H requires that the decisions to be sent via certified mail.

In addition A.R.S. Section 38-847.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 and all necessary communications 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.

Medical Reports and Documentation Supporting Award of Disability

Copies of all medical evidence, including the Independent Medical Evaluation considered by the Local Board in reaching it's determination on eligibility must be forwarded to the Board of Trustee's Administrative Office for compliance review. The member's application packet should also be included with these documents.

Health Insurance Plans and Subsidy Available to Retirees

Retiring Public Safety Personnel Retirement System (PSPRS) 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 PSPRS 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)
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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. <u>Short title</u>

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

Sec. 4. <u>Retroactivity</u>

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

Sec. 5. <u>Emergency</u>

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.

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

ACCIDENTAL DISABILITY PROCESS OUTLINE

1. Applicant files Application for Disability Retirement (Form P5-EE) with Local Board.
2. Local Board sets meeting to determine whether the applicant has filed the application after the disabling incident or within one year after the date the member ceases to be an employee. A member is eligible for an accidental disability if the member's employment is terminated by reason of accidental disability (38-844.B).
3. If medical evidence and application warrants appointment of the independent medical evaluation (IME), then the Local Board appoints a Medical Board to perform an IME of the applicant.
4. Local Board forwards a copy of claimant's P5-EE, Application for Disability Retirement, which includes a medical release authorization for prior treatment records, and a copy of the applicant's medical records to the appointed Medical Board. The Local Board must direct the Medical Board to complete Form P5-LB-A, Accidental Disability Questionnaire. In addition to the Form P5-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 his job classification? Providing the Medical Board with a description of the duties required of police officers or fire fighters with the particular employer should help the Medical Board address this issue.
   b. Does the claimant's disability result from a physical or mental condition or injury that existed or occurred prior to the claimant's date of membership in the PSPRS?
   c. Was the disabling condition or injury incurred in the performance of claimant's duty as a police officer or fire fighter? Any departmental accident reports or documentation of an on-the-job injury should be provided to the Medical Board.
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 three issues presented to the Medical Board above. Statutes requires that a Local Board's "finding of accidental disability shall be based on medical evidence by a doctor or clinic appointed by the local board...which establishes an accidental disability." Any motion to approve or disapprove a claimant's application for Accidental Disability should include a reference to the Medical Board evaluation upon which the determination is based. A Local Board can consider any medical evidence that the claimant may want to provide; however, the statute is clear that an award of an accidental disability shall be based on 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 Retirement is approved, the Local Board Chairman or Secretary completes the determination section on the Form P5-LB and forwards it to the Board of Trustee's Administrative Office together with completed Forms P5-EE, P5-LB-A Disability Questionnaire, P11D, P12 and 13, A-4P, W-4P and P8 (optional) and supporting documentation (birth certificates, marriage certificates, etc.) along with a copy of the Local Board meeting minutes approving the accidental disability. The Local Board must also forward 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.

   A.R.S. Section 38-847.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" and 38-847.H requires that the decisions to be sent via certified mail.

7. Appeals for Rehearing of a Local Board's decision may be requested by the claimant or Board of trustees as set forth in statutes.

8. Payment of an accidental disability pension shall commence as of the first day of the month following the date of retirement or the expiration of a period during which the member is receiving sick leave payments or a temporary disability pension, whichever is later. The last payment shall be made as of the last day of the month in which the death of the retired member occurs, or if disability ceases prior to his normal retirement date, the first day of the month in which disability ceases. The monthly accidental disability pension amount is calculated like a normal retirement using actual credited service or 20 years, whichever is greater.

9. Accidental disability shall be considered to have ceased and an accidental disability pension terminates if the member:

    a. has sufficiently recovered in the opinion of the Local Board, based on medical evidence from a Medical Board appointed by the Local Board, to be able to engage in a reasonable range of duties within his department and the member refuses an offer of employment by an employer in the PSPRS; or

    b. refuses to undergo any medical examination requested by the Local Board (cannot be requested more than once in any calendar year)

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

TEMPORARY DISABILITY PROCESS OUTLINE

1. Applicant files Application for Temporary Disability (Form P5-EE) with Local Board.

2. Local Board sets meeting to determine whether the applicant has terminated employment prior to their normal retirement date by reason of temporary disability (38-844.I).

3. If medical evidence and application warrants appointment of the independent medical evaluation (IME), then the Local Board appoints a Medical Board to perform an IME of the applicant.

4. Local Board forwards a copy of claimant's P5-EE, Application for Disability Retirement, which includes a medical release authorization for prior treatment records, and a copy of the applicant's medical records to the appointed Medical Board. The Local Board must direct the Medical Board to complete Form P5-LB-T, Temporary Disability Questionnaire. In addition to the Form P5-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 temporarily prevents him from performing a reasonable range of duties within his department? Providing the Medical Board with a description of the duties required of police or fire fighters with the particular employer should help the Medical Board address this issue. The anticipated duration of the claimant's disability to perform a reasonable range of duties should be less than twelve months and should be so stated in the medical evaluation.

   b. Was the disabling injury or condition incurred in the performance of claimant's duty as a police officer or fire fighter? Any departmental accident reports or documentation of an on-the-job injury should be provided to the Medical Board.

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 two issues presented to the Medical Board above. Statutes requires that a Local Board's "finding of disability shall be based on medical evidence by a doctor or clinic appointed by the local board...which establishes a temporary disability." Any motion to approve or disapprove a claimant's application for Temporary Disability should include a reference to the Medical Board evaluation upon which the determination is based. A Local Board can consider any medical evidence that the claimant may want to provide; however, the statute is clear that an award of a Temporary Disability shall be based on 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 Retirement is approved, the Local Board Chairman or Secretary completes the determination section on the Form P5-LB and forwards it to the Board of Trustee's Administrative Office together with completed Forms P5-EE, P5-LB-T Disability Questionnaire, P11D, P12 and 13, A-4P, W-4P and P8 (optional) and supporting documentation (birth certificates, marriage certificates, etc.) along with a copy of the Local Board meeting minutes approving the accidental disability. The Local Board must also forward 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.

   A.R.S. Section 38-847.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" and 38-847.H requires that the decisions to be sent via certified mail.

7. Appeals for Rehearing of a Local Board's decision may be requested by the claimant or Board of trustees as set forth in statutes.

8. Payment of a Temporary Disability pension shall commence as of the first day of the month following the date of disability or the expiration of a period during which the member is receiving compensation and sick leave payments, whichever is later. The last payment shall be made as of the first day of the month in which either the death of the member occurs or the Local Board deems the member is no longer under Temporary Disability, whichever occurs first, provided that NO MORE THAN TWELVE MONTHLY TEMPORARY DISABILITY PAYMENTS shall be made in

total to the member. The monthly temporary disability pension amount is equal to one-twelfth of fifty per cent of his annual benefit compensation received immediately prior to the date on which his disability was incurred.

9. If upon the expiration of a Temporary Disability pension the Local Board finds upon application that the member has an Accidental or Ordinary Disability, the member shall thereupon be eligible for an Accidental or Ordinary Disability pension.

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

ORDINARY DISABILITY PROCESS OUTLINE

1. Applicant files Application for Ordinary Disability (Form P5-EE) with Local Board.

2. Local Board sets meeting to determine whether the applicant has filed the application after the disabling incident or within one year after the date the member ceases to be an employee. A member is eligible for an ordinary disability pension if the member's employment is terminated before the member's normal retirement date by reason of ordinary disability (38-844.B).

3. If medical evidence and application warrants appointment of the independent medical evaluation (IME), then the Local Board appoints a Medical Board to perform an IME of the applicant.

4. Local Board forwards a copy of claimant's P5-EE, Application for Disability Retirement, which includes a medical release authorization for prior treatment records, and a copy of the applicant's medical records to the appointed Medical Board. The Local Board must direct the Medical Board to complete Form P5-LB-O, Accidental Disability Questionnaire. In addition to the Form P5-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. (1) Does the claimant have a PHYSICAL CONDITION which totally and permanently prevents him from performing a reasonable range of duties within his department? Providing the Medical Board with a description of the duties required of police or fire fighters with the particular employer should help the Medical Board address this issue.

   OR

   (2) Does the claimant have a MENTAL CONDITION which totally and permanently prevents him from engaging in any substantial gainful activity?

   b. Does the claimant's disability result from a physical or mental condition or injury that existed or occurred prior to the member's date of membership in the PSPRS?

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 above. Statutes requires that a Local Board's "finding of ordinary disability shall be based on medical evidence by a doctor or clinic appointed by the local board...which establishes an ordinary disability." Any motion to approve or disapprove a claimant's application for Ordinary Disability should include a reference to the Medical Board evaluation upon which the determination is based. A Local Board can consider any medical evidence that the claimant may want to provide; however, the statute is clear that an award of an ordinary disability shall be based on the appointed Medical Board's evaluation. Material conflicts in medical evidence shall be resolved by the findings of the Local Board. Disability determination by the State Comp Fund or other workers' compensation bodies are not binding on the Local Board.

6. Once an Application for Disability Retirement is approved, the Local Board Chairman or Secretary completes the determination section on the Form P5-LB and forwards it to the Board of Trustee's Administrative Office together with completed Forms P5-EE, P5-LB-O Disability Questionnaire, P11D, P12 and 13, A-4P, W-4P and P8 (optional) and supporting documentation (birth certificates, marriage certificates, etc.) along with a copy of the Local Board meeting minutes approving the accidental disability. The Local Board must also forward 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.

A.R.S. Section 38-847.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" and 38-847.H requires that the decisions to be sent via certified mail.

7. Appeals for Rehearing of a Local Board's decision may be requested by the claimant or Board of trustees as set forth in statutes.

8. Payment of an ordinary disability pension shall commence as of the first day of the month following the date of retirement or the expiration of a period during which the member is receiving sick leave payments or a temporary disability pension, whichever is later. The last payment shall be made as of the last day of the month in which the death of the retired member occurs, or if disability ceases prior to the member's normal retirement date, the first day of the month in which disability ceases.

9. The monthly ordinary disability pension amount is based on the claimant's actual credited service. The retiree receives a monthly amount equal to 50% of the member's average monthly salary multiplied by years of credited service and divided by twenty.

10. Ordinary disability shall be considered to have ceased and an ordinary disability pension terminates if the member:

    a. Has sufficiently recovered in the opinion of the Local Board, based on medical evidence from a Medical Board appointed by the Local Board, to be able to engage in a reasonable range of duties within his department and the member refuses an offer of employment by an employer in the system; or

    b. Refuses to undergo any medical examination requested by the Local Board (cannot be requested more than once in any calendar year).

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

CATASTROPHIC DISABILITY PROCESS OUTLINE

1. Applicant files Application for Catastrophic Disability (Form P5-EE) with Local Board.
2. Local Board sets meeting to determine whether the applicant has filed the application after the disabling incident or within one year after the date the member ceases to be an employee. A member is eligible for a catastrophic disability pension if the member's employment is terminated by reason of catastrophic disability (38-844.C).
3. If medical evidence and application warrants appointment of the independent medical evaluation (IME), then the Local Board appoints a Medical Board to perform an IME of the applicant.
4. Local Board forwards a copy of claimant's P5-EE, Application for Disability Retirement, which includes a medical release authorization for prior treatment records, and a copy of the applicant's medical records to the appointed Medical Board. The Local Board must request the Medical Board to complete Form P5-LB-C, Accidental Disability Questionnaire. In addition to the Form P5-LB-C, 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 engaging in any gainful employment?
   b. Does the claimant's disability result from a physical condition or injury that existed or occurred prior to the claimant's date of membership in the PSPRS?
   c. Was the disabling condition or injury incurred in the performance of claimant's duty as a police officer or fire fighter? Any departmental accident reports or documentation of an on-the-job injury should be provided to the Medical Board.
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 three issues presented to the Medical Board above. Statutes requires that a Local Board's "finding of…catastrophic disability shall be based on medical evidence by a physician or clinic appointed by the local board...that establishes the disability." Any motion to approve or disapprove a claimant's application for Catastrophic Disability should include a reference to the Medical Board evaluation upon which the determination is based. A Local Board can consider any medical evidence that the claimant may want to provide; however, the statute is clear that an award of an catastrophic disability shall be based on 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 Retirement is approved, the Local Board Chairman or Secretary completes the determination section on the Form P5-LB and forwards it to the Board of Trustee's Administrative Office together with completed Forms P5-EE, P5-LB-C Disability Questionnaire, P11D, P12 and 13, A-4P, W-4P and P8 (optional) and supporting documentation (birth certificates, marriage certificates, etc.) along with a copy of the Local Board meeting minutes approving the accidental disability. The Local Board must also forward 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.

   A.R.S. Section 38-847.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" and 38-847.H requires that the decisions to be sent via certified mail.
7. Appeals for Rehearing of a Local Board's decision may be requested by the claimant or Board of trustees as set forth in statutes.

8. Payment of a catastrophic disability pension shall commence as of the first day of the month following the date of retirement or the expiration of a period during which the member is receiving sick leave payments or a temporary disability pension, whichever is later. The last payment shall be made as of the last day of the month in which the death of the retired member occurs, or if the disability ceases because the member has sufficiently recovered and is able to engage in gainful employment. The monthly catastrophic disability pension amount is ninety per cent of the member's average monthly benefit compensation for the first sixty months. Thereafter, the local board shall reevaluate the member. If the member still qualifies for a catastrophic disability, the benefit is reduced to either sixty-two and one-half per cent of the member's average monthly benefits compensation or computed in the same manner as a normal pension using the member's actual credited service, whichever is greater.

9. Catastrophic disability shall be considered to have ceased and a catastrophic disability pension terminates if:

   a. The local board determines that the member has sufficiently recovered and is able to engage in gainful employment based on a medical examination by a physician or a clinic appointed by the local board; or

   b. Refuses to refuses to undergo any medical examination requested by the Local Board (cannot be requested more than once in any calendar year).

10. A member whose catastrophic disability pension is terminated may apply for and if eligible, is entitled to receive an accidental disability pension.

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

STRESS DISABILITY LEGAL GUIDELINES

Excerpts from the Arizona Court of Appeals Decision in Wills -v- Pima County Public Safety Personnel Retirement Board 154 Ariz. 435 (1987) regarding emotional stress disability applicants:

This decision requires an interpretation of A.R.S. Section 38-842 as it existed in 1970.

38-842. Definitions

In this article, unless the context otherwise requires:

1. "Accidental disability" means a physical or mental condition which, in the judgment of the board, totally and presumably permanently prevents an employee from performing his regularly assigned duties and was incurred in the performance of his duty. A determination of disability shall be based on medical evidence satisfactory to the board.

What did the legislature intend by the words, "incurred in the performance of the employee's duty?" Although "incurred" has many definitions, we believe that in the context of the statute defining "accidental disability" it can only mean "to occur as a result." Webster's Third New International Dictionary Unabridged at 1146 (1971). Therefore, entitlement to an accidental disability pension depends on evidence sufficient to establish a causal relationship between Wills' disability and his duties as a police officer.

Wills' medical expert testified that his job stress contributed to his condition but could not give an opinion as to any degree of contribution.... "We are prevented from re-weighing the evidence, and since there was substantial evidence to support the determination of no causal connection by the retirement board and the trial court, we must affirm...."
Wills argues that he is entitled to a disability pension "if (his) work as a police officer aggravates a condition to the extent it

"becomes disabling" and "the statute does not state that a mental or physical condition must be 'caused' by the policeman's work, but says it must be incurred in policeman's work." Wills supports this argument by citing cases involving workers' compensation...."

Workers' compensation is a statutory scheme peculiar to employer/employee relationships which has as its purpose compensation for work-related occurrences without regard to fault. The pension plan involved here is unrelated to workers' compensation and is a fund from which retired police officers are paid benefits after termination of employment and fulfillment of all statutory requirements by the member for the pension, A.R.S. Sections 38-841 and 38-842(19). It provides for payment of benefits before qualifying for normal retirement if a member is accidentally disabled. A.R.S. Section 38-842(1). Although Arizona workers' compensation cases are based on a very liberal interpretation of medical causation in order to entitle a worker to benefits, they are useful in assisting us in our determination that "incurred in the performance of his duty" means proof of a causal relationship between the disability and duties as a police officer. Arizona workers' compensation cases have held that heart-related disabilities allegedly caused by job stress are not compensable unless the job stress was a substantial contributing cause of the heart-related illness. A.R.S. Section 23-1043.01(a) See also Skyview Cooling Co. -v- Industrial Commission, 142 Ariz. 554, 559, 691 P.2d 320, 325 (App. 1984) (more than insubstantial or slight); Bush -v- Industrial Commission, 136 Ariz. 522, 524, 667 P.2d 222,224 (1983) (requiring a recognizable causal connection showing that the exertions or work of the job precipitated the heart attack): Sloss -v- Industrial Commission, 121 Ariz. 10, 588 P.2d 303 (1978) (exposure to nothing other than the usual, ordinary and expected incidents of a job as highway patrolman is not compensable)....

Causal connection means more than just a contribution factor.... The medical witnesses either could not find any causal connection between Wills' duties as a police officer and his heart condition or found that the job was only an

insignificant contributing factor. Therefore, there was sufficient medical evidence to support the finding of the retirement board and the superior court that Wills was not entitled to a permanent disability pension under the provisions of A.R.S. Section 38-842 because his job stress neither caused nor contributed to his heart condition or there was no causal connection between his employment and his heart condition.

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

DUE PROCESS GUIDELINES FOR DISABILITY REHEARINGS

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

A.R.S. Section 38-847 provides, in part, as follows:

G. Any action by a majority vote of the members of a local board that is not inconsistent with the provisions of the system and the internal revenue code shall be final, conclusive and binding upon all persons affected by it, unless a timely application for rehearing or appeal is filed as provided in this article.

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

> 1. The applicant-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 system pursuant to the local board's original action, whichever occurs first.
>
> 2. The applicant-board of trustees receives notification of the local board's original action as prescribed by subsection G of this section by certified mail.

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 applicant-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 Application with notification to the applicant of their statutory right to apply for a rehearing within the time period prescribed above. The PSPRS 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 insure 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. In the event there is not an 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 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 reasons why they are entitled to the disability retirement. The burden of proof for establishing the disability rests with the applicant.

The PSPRS statute effectively limits the evidence upon which the Local Board can base their determination in disability applications by prescribing "a finding of...disability shall be based on medical evidence by a doctor or clinic appointed by the local board pursuant to section 38-847.D.9 which establishes a...disability". These same statutes provide that "material conflicts in medical evidence shall be resolved by the findings of the local board". 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.

In some cases, 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 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 re-evaluation by the Local Board's designated doctor or refer the applicant to a new doctor designated by the Local Board pursuant to the statutes.

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 board of trustees 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.

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

A GUIDE TO PROCESSING AN ACCIDENTAL, CATASTROPHIC OR ORDINARY DISABILITY RETIREMENT

The following letters and procedures are intended to be a guide in processing an accidental, catastrophic or ordinary disability retirement under the Public Safety Personnel Retirement System.

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

August 22, 2011

Re: Disability Application - Public Safety Personnel Retirement System

Dear Mr. Smith:

Per your request of this date, I am enclosing an Application for Disability Retirement (Form P5-EE) and the applicable Public Safety Personnel Retirement System 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 section on page 2 of Form P5-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

August 29, 2011

Re: Application for Disability Retirement - Public Safety Personnel Retirement System

Dear Mr. Smith:

The Public Safety Personnel Retirement System Local Board for the City of xxxx has received your Application for Disability Retirement dated August 28, 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 PSPRS, A.R.S. Section 38-859, subsection B, 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 this 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

September 2, 2011

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

Re: Smith - Application for Disability Retirement - Public Safety Personnel Retirement System

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

September 9, 2011

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

Re: Mr. Smith - Disability Application - Public Safety Personnel Retirement System

Dear Doctor Young:

I represent the City of xxxx Public Safety Personnel Retirement System Local Board, a retirement system for city police officers and firefighters.

Mr. Smith, a ___________ for the city of xxxx, has recently applied for a medical disability retirement under the Public Safety Personnel Retirement System. 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 August 8, 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**: *If the member is applying for an ordinary, catastrophic or temporary disability, use the applicable legal standard*)

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 job classification? For your information I am enclosing a copy of the duties which are required of a ___________ for the city 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 PSPRS? For your information, Mr. Smith began employment with the city as a full-time ___________ on August 1, 1992.

Tony Young, M.D.
September 9, 2011
Page -2-

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

September 30, 2011

Re: Application for Disability Retirement - Public Safety Personnel Retirement System

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 October 14, 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 that 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 the open meeting 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

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
3010 E. Camelback Rd., Suite 200, Phoenix, AZ 85016
(602) 255-5575 FAX (602) 296-2369 www.psprs.com

FORM P5-LB-A
08/2011

ACCIDENTAL DISABILITY QUESTIONNAIRE

Completed by Local Board and Doctor (if applicable)

Pursuant to A.R.S. §§ 38-842(1), 38-844 and 38-845, 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 job classification and that was incurred in the performance of the employee's duty.	LOCAL BOARD Initial Response			
1. Did the employee terminate employment by reason of disability?		YES		NO
2. Did the employee file the application after the disabling incident or within one year of ceasing to be an employee?		YES		NO
3. Is the employee still working in a job the board believes is a reasonable range of duties?		YES		NO
4. 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
5. Has the member refused a job the board believes is a reasonable range of duties?		YES		NO
6. Did the **employer** terminate the employee's employment based on a physical or mental condition?		YES		NO
7. Did the **employer** terminate the employee's employment based on a disciplinary issue?		YES		NO
8. Did the **member** terminate employment based on a physical or mental condition?		YES		NO
9. Did the **member** terminate employment based on participation in DROP?		YES		NO
10. Was the injury the result of an event incurred during the performance of the member's duty?		YES		NO
11. 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 P5-LB and forward to PSPRS. 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. Does the condition **permanently** prevent the member from performing a reasonable range of duties within the employee's job classification?		YES		NO
4. Does the condition **totally** prevent the member from performing a reasonable range of duties within the employee's job classification?		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. 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

FORM P5-LB-O
08/2011

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

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

(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. §§ 38-842(34), 38-844 and 38-845, an "Ordinary disability" means a physical condition that the local board determines will prevent an employee totally and permanently from performing a reasonable range of duties within the employee's department, or a mental condition that the local board determines will prevent an employee totally and permanently from engaging in any substantial gainful activity and that was incurred in the performance of the employee's duty.	**LOCAL BOARD Initial Response**			
1. Did the employee terminate employment by reason of disability?		YES		NO
2. Did the employee file the application after the disabling incident or within one year of ceasing to be an employee?		YES		NO
3. Is the member still working in a job the board believes is a reasonable range of duties?		YES		NO
4. 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
5. Has the member refused a job the board believes is a reasonable range of duties?		YES		NO
6. Did the **employer** terminate the member's employment based on a physical or mental condition that is being applied for?		YES		NO
7. Did the **employer** terminate the employee's employment based on a disciplinary issue?		YES		NO
8. Did the **member** terminate employment based on a physical or mental condition?		YES		NO
9. Did the **member** terminate employment based on participation in DROP?		YES		NO
10. Was the condition a result of a non-duty related event?		YES		NO
11. 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 P5-LB and forward to PSPRS. 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. Does the physical condition **permanently** prevent the member from performing a reasonable range of duties within the employee's department?		YES		NO
4. Does the physical condition **totally** prevent the member from performing a reasonable range of duties within the employee's department?		YES		NO
5. Does the mental condition **permanently** prevent the member from engaging in any substantial gainful activity?		YES		NO
6. Does the mental condition **totally** prevent the member from engaging in any substantial gainful activity?		YES		NO
7. 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
8. 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
9. Did the condition or injury occur prior to the member's membership in the Plan?		YES		NO
10. 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

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
3010 E. Camelback Rd., Suite 200, Phoenix, AZ 85016
(602) 255-5575 FAX (602) 296-2369 www.psprs.com

FORM P5-LB-T
08/2011

TEMPORARY DISABILITY QUESTIONNAIRE

Completed by Local Board and Doctor (if applicable)

Pursuant to A.R.S. §§ 38-842(46), 38-844 and 38-845, a "Temporary disability" means a physical or mental condition that the local board finds totally and temporarily prevents an employee from performing a reasonable range of duties within the employee's department and that was incurred in the performance of the employee's duty.	**LOCAL BOARD Initial Response**			
1. Did the employee terminate employment by reason of temporary disability?		YES		NO
2. Did the employee terminate employment before their normal retirement date?		YES		NO
3. 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
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 participation in DROP?		YES		NO
8. Is the member still working in a job the board believes is a reasonable range of duties?		YES		NO
9. Has the member refused a job the board believes is a reasonable range of duties?		YES		NO
10. Was the injury the result of an event incurred during the performance of the member's duty?		YES		NO

LOCAL BOARD INSTRUCTIONS: If it is determined that the employee does not qualify, complete FORM P5-LB and forward to PSPRS. 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. Does the condition **temporarily** prevent the member from performing a reasonable range of duties within the employee's department?		YES		NO
4. Does 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 determine the member may be able to return to work in the next 12 months? If no, address in IME report.		YES		NO
7. 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
8. Was the injury the result of an event incurred during the performance of the member's duty?		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

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

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

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

FORM P5-LB-C
08/2011

CATASTROPHIC DISABILITY QUESTIONNAIRE

Completed by Local Board and Doctor (if applicable)

Pursuant to A.R.S. §§ 38-842(8), 38-844, 38-845 and Section 11, a "Catastrophic disability" means a physical and not a psychological condition that the local board determines prevents the employee from totally and permanently engaging in any gainful employment and that results from a physical injury incurred in the performance of the employee's duty.	**LOCAL BOARD Initial Response**			
1. Did the employee terminate employment by reason of disability?		YES		NO
2. Did the employee file the application after the disabling incident or within one year of ceasing to be an employee?		YES		NO
3. Does the employer have any jobs available for the member the board believes is gainful employment?		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 this physical condition?		YES		NO
7. Did the **member** terminate employment based on participation in DROP?		YES		NO
8. Is the member working in a job the board believes is gainful employment?		YES		NO
9. Has the member refused a job the board believes is gainful employment?		YES		NO
10. Was the injury incurred in the performance of the employee's duty?				
11. Was the injury the result of an event incurred during the performance of the member's duty?		YES		NO

LOCAL BOARD INSTRUCTIONS: If it is determined that the employee does not qualify, complete FORM P5-LB and forward to PSPRS. 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 physical condition **permanently** prevent the member from engaging in any gainful employment?		YES		NO
3. Does the physical condition **totally** prevent the member from engaging in any gainful employment?		YES		NO
4. 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
5. 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
6. Was the injury the result of an event incurred during the performance of the member's duty?		YES		NO
7. 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

08/11

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.

<u>If you do a direct rollover</u>, 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.

<u>If you do not do a direct rollover</u>, 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 ½, 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) ☐Non-retired ☐Retired
Date of Birth (MM/DD/YYYY)	Gender (check one) ☐ Male ☐ 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

- An **AUTOMATIC** survivor benefit will pay your:
  - **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 *Beneficiary Designation Form* after the date of the divorce.

☒ **Primary**

SSN	Name of Beneficiary (Last, First, Middle)	Relationship (check one) ☐Spouse ☐Child ☐Parent ☐Fiancé ☐Friend ☐Other
Birth Date (MM/DD/YYYY)	Address (City, State, ZIP Code +4)	Telephone # ( )

Check ONE ☐ Primary OR ☐ Secondary (If not checked, the following beneficiary is a primary beneficiary)

SSN	Name of Beneficiary (Last, First, Middle)	Relationship (check one) ☐Spouse ☐Child ☐Parent ☐Fiancé ☐Friend ☐Other
Birth Date (MM/DD/YYYY)	Address (City, State, ZIP Code +4)	Telephone # ( )

Check ONE ☐ Primary OR ☐ Secondary (If not checked, the following beneficiary is a primary beneficiary)

SSN	Name of Beneficiary (Last, First, Middle)	Relationship (check one) ☐Spouse ☐Child ☐Parent ☐Fiancé ☐Friend ☐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.**

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

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) ☐Non-retired ☐Retired ☐Survivor/Guardian ☐Ex-spouse ☐Refunding	
RETIREE SYSID (if known)	Gender (check one) ☐ Male ☐ 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.

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

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016
(602)255-5575 FAX (602)296-2369 www.psprs.com

APPLICATION FOR NORMAL RETIREMENT

TO: LOCAL RETIREMENT BOARD DATE: _______/_______/_______

Having either (1) reached age 62 with 15 or more years of service **OR** (2) completed 20 or more years of service at time of termination with the (employer name)____, I, (name) ____, hereby submit my application for normal retirement under the terms of the Arizona Public Safety Personnel Retirement System. I am retiring on (date) _______/_______/_______, 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 38-844.(A)). If application is being made under A.R.S. Section 38-854, 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

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 NORMAL RETIREMENT

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)

	Missed Pay Periods	Employer
1.		
2.		
3.		
4.		
5.		

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.

____________________________________ ____________________________________
WITNESS SIGNATURE MEMBER'S SIGNATURE

DATE _______/_______/______

EMPLOYER'S CERTIFICATION OF RETIREMENT DATE:

Member's employment will terminate on ____

BY____________________________________
Signature

____
Title

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

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

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

FORM P4D
08/11

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 Public Safety Personnel Retirement System (A.R.S. Section 38-846.01). 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 PSPRS 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 DEFERRED ANNUITY

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)

	Missed Pay Periods	Employer
1.		
2.		
3.		
4.		
5.		

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 annuity benefits.

______________________________ ______________________________
WITNESS SIGNATURE MEMBER'S SIGNATURE

DATE _______/_______/______

EMPLOYER'S CERTIFICATION OF TERMINATION DATE:

Member's employment terminated on ____

BY______________________________
Signature

____
Title

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
3010 E. Camelback Rd., Suite 200, Phoenix, AZ 85016
(602) 255-5575 FAX (602) 296-2369 www.psprs.com

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 ☐ Ordinary ☐ Temporary ☐ Catastrophic

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
☐ Spouse ☐ Not applicable					
☐ Child ☐ Not applicable					
☐ Child					
☐ Child					

EMPLOYEE: Copy for your records and send **ORIGINAL** to your Local Board.

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
3010 E. Camelback Rd., Suite 200, Phoenix, AZ 85016
(602) 255-5575 FAX (602) 296-2369 www.psprs.com

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 Public Safety Personnel Retirement System (PSPRS), 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. § 38-847(F), 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 PSPRS. 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. § 38-849.B 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

Rev. 01/23/2012 **EMPLOYEE:** Copy for your records and send **ORIGINAL** to your Local Board.

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
3010 E. Camelback Rd., Suite 200, Phoenix, AZ 85016
(602) 255-5575 FAX (602) 296-2369 www.psprs.com

FORM P5-LB
08/11

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 P5-EE, complete the applicable *DISABILITY QUESTIONNAIRE* (i.e., FORM P5-LB-**A**, FORM P5-LB-**O**, P5-LB-**T** or P5-LB-**C**).

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 ☐ Not Working ☐ Limited Duty ☐ Unpaid Leave
☐ Working Part-time ☐ Regular Assignment ☐ Paid Leave Other ____________________

DETERMINATION - Pursuant to A.R.S. §§ 38-847 and 38-859, 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 an ORDINARY DISABILITY retirement pension effective ____/____/____

☐ Qualifies for a TEMPORARY DISABILITY retirement pension effective ____/____/____

☐ Qualifies for a CATASTROPHIC DISABILITY retirement pension effective ____/____/____

Effective July 20, 2011, A.R.S. § 38-845.02 states that: "The Board shall not make a retroactive payment of a pension of a person that is more than ninety days before the date of the person's application for benefits."

PRINT Name of Local Board Secretary or Chairman ______________________ **Signature** ______________________ **Board Meeting Motion Date** ______________________

Pursuant to A.R.S. § 38-847(F), 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 (P5-LB) form, P5-EE, *DISABILITY QUESTIONNAIRE* and provide the Medical Examination (if applicable), Local Board meeting minutes (sent via certified mail pursuant to A.R.S. § 38-847.F), and "REQUIRED DOCUMENTS" as indicated on FORM P5-EE.

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

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

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

FORM P5-LB-A

08/11

ACCIDENTAL DISABILITY QUESTIONNAIRE

Completed by Local Board and Doctor (if applicable)

Pursuant to A.R.S. §§ 38-842(1), 38-844 and 38-845, 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 job classification and that was incurred in the performance of the employee's duty.	**LOCAL BOARD Initial Response**			
1. Did the employee terminate employment by reason of disability?		YES		NO
2. Did the employee file the application after the disabling incident or within one year of ceasing to be an employee?		YES		NO
3. Is the employee still working in a job the board believes is a reasonable range of duties?		YES		NO
4. 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
5. Has the member refused a job the board believes is a reasonable range of duties?		YES		NO
6. Did the **employer** terminate the employee's employment based on a physical or mental condition?		YES		NO
7. Did the **employer** terminate the employee's employment based on a disciplinary issue?		YES		NO
8. Did the **member** terminate employment based on a physical or mental condition?		YES		NO
9. Did the **member** terminate employment based on participation in DROP?		YES		NO
10. Was the injury the result of an event incurred during the performance of the member's duty?		YES		NO
11. 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 P5-LB and forward to PSPRS. 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. Does the condition **permanently** prevent the member from performing a reasonable range of duties within the employee's job classification?		YES		NO
4. Does the condition **totally** prevent the member from performing a reasonable range of duties within the employee's job classification?		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. 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

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

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

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

FORM P5-LB-O

08/11

ORDINARY DISABILITY QUESTIONNAIRE

Completed by Local Board and Doctor (if applicable)

Pursuant to A.R.S. §§ 38-842(34), 38-844 and 38-845, an "Ordinary disability" means a physical condition that the local board determines will prevent an employee totally and permanently from performing a reasonable range of duties within the employee's department, or a mental condition that the local board determines will prevent an employee totally and permanently from engaging in any substantial gainful activity and that the physical or mental condition or injury did not occur before the employee's date of membership in the System.	**LOCAL BOARD Initial Response**			
1. Did the employee terminate employment by reason of disability?		YES		NO
2. Did the employee file the application after the disabling incident or within one year of ceasing to be an employee?		YES		NO
3. Is the member still working in a job the board believes is a reasonable range of duties?		YES		NO
4. 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
5. Has the member refused a job the board believes is a reasonable range of duties?		YES		NO
6. Did the **employer** terminate the member's employment based on a physical or mental condition that is being applied for?		YES		NO
7. Did the **employer** terminate the employee's employment based on a disciplinary issue?		YES		NO
8. Did the **member** terminate employment based on a physical or mental condition?		YES		NO
9. Did the **member** terminate employment based on participation in DROP?		YES		NO
10. Was the condition a result of a non-duty related event?		YES		NO
11. 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 P5-LB and forward to PSPRS. 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. Does the physical condition **permanently** prevent the member from performing a reasonable range of duties within the employee's department?		YES		NO
4. Does the physical condition **totally** prevent the member from performing a reasonable range of duties within the employee's department?		YES		NO
5. Does the mental condition **permanently** prevent the member from engaging in any substantial gainful activity?		YES		NO
6. Does the mental condition **totally** prevent the member from engaging in any substantial gainful activity?		YES		NO
7. 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
8. 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
9. Did the condition or injury occur prior to the member's membership in the Plan?		YES		NO
10. 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

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

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

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

FORM P5-LB-T

08/11

TEMPORARY
DISABILITY QUESTIONNAIRE

Completed by Local Board and Doctor (if applicable)

Pursuant to A.R.S. §§ 38-842(46), 38-844 and 38-845, a "Temporary disability" means a physical or mental condition that the local board finds totally and temporarily prevents an employee from performing a reasonable range of duties within the employee's department and that was incurred in the performance of the employee's duty.	**LOCAL BOARD Initial Response**			
1. Did the employee terminate employment by reason of temporary disability?		YES		NO
2. Did the employee terminate employment before their normal retirement date?		YES		NO
3. 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
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 participation in DROP?		YES		NO
8. Is the member still working in a job the board believes is a reasonable range of duties?		YES		NO
9. Has the member refused a job the board believes is a reasonable range of duties?		YES		NO
10. Was the injury the result of an event incurred during the performance of the member's duty?		YES		NO

LOCAL BOARD INSTRUCTIONS: If it is determined that the employee does not qualify, complete FORM P5-LB and forward to PSPRS. 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. Does the condition **temporarily** prevent the member from performing a reasonable range of duties within the employee's department?		YES		NO
4. Does 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 determine the member may be able to return to work in the next 12 months? If no, address in IME report.		YES		NO
7. 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
8. Was the injury the result of an event incurred during the performance of the member's duty?		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

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM **FORM P5-LB-C**

08/11

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

CATASTROPHIC DISABILITY QUESTIONNAIRE

Completed by Local Board and Doctor (if applicable)

Pursuant to A.R.S. §§ 38-842(8), 38-844, 38-845 and Section 11, a "Catastrophic disability" means a physical and not a psychological condition that the local board determines prevents the employee from totally and permanently engaging in any gainful employment and that results from a physical injury incurred in the performance of the employee's duty.	**LOCAL BOARD Initial Response**			
1. Did the employee terminate employment by reason of disability?		YES		NO
2. Did the employee file the application after the disabling incident or within one year of ceasing to be an employee?		YES		NO
3. Does the employer have any jobs available for the member the board believes is gainful employment?		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 this physical condition?		YES		NO
7. Did the **member** terminate employment based on participation in DROP?		YES		NO
8. Is the member working in a job the board believes is gainful employment?		YES		NO
9. Has the member refused a job the board believes is gainful employment?		YES		NO
10. Was the injury incurred in the performance of the employee's duty?				
11. Was the injury the result of an event incurred during the performance of the member's duty?		YES		NO

LOCAL BOARD INSTRUCTIONS: If it is determined that the employee does not qualify, complete FORM P5-LB and forward to PSPRS. 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 physical condition **permanently** prevent the member from engaging in any gainful employment?		YES		NO
3. Does the physical condition **totally** prevent the member from engaging in any gainful employment?		YES		NO
4. 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
5. 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
6. Was the injury the result of an event incurred during the performance of the member's duty?		YES		NO
7. 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

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016
(602)255-5575 FAX (602)296-2369 www.psprs.com

APPLICATION FOR DEATH BENEFIT

DATE: _______/_______/_______

TO: LOCAL RETIREMENT BOARD

I hereby submit my application for a death benefit under the terms of the Arizona Public Safety Personnel Retirement System.

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 PSPRS _________________ **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

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016
(602)255-5575 FAX (602)296-2369 www.psprs.com

APPLICATION FOR A SURVIVOR'S BENEFIT

TO: LOCAL RETIREMENT BOARD DATE: _______/_______/_______

I hereby submit my application for a survivor's benefit under the terms of the Public Safety Personnel Retirement System.

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

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

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016
(602)255-5575 FAX (602)296-2369 www.psprs.com

NOTIFICATION OF BENEFITS AND ELECTION

DATE RETIRED: ____/____/____

MEMBER'S NAME: ________________________________ DATE FIRST PAYMENT DUE: _______/_______/_______

PAYABLE TO: ____
(Name of Member, Survivor or Guardian)

TYPE OF BENEFIT: ☐ Normal Retirement ☐ Deferred Annuity ☐ Ordinary Disability
☐ Catastrophic ☐ Temporary Disability ☐ Accidental Disability ☐ Survivor ☐ Guardian

1. BENEFITS UNDER ARIZONA PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM:

a) Monthly pension payable to member: .... $ ____________________

b) Monthly pension payable to surviving spouse or guardian:
If applicant is a member, the spouse's benefit shown here will be payable upon death of the retired member. The spouse's benefit ceases upon death; the guardian's benefit ceases when youngest child is no longer eligible. (A.R.S. 38-846) .... $ ____________________

c) Monthly benefit payable to each eligible child under age 18 and unmarried, or disabled. (A.R.S. 38-842) .... $ ____________________

2. BENEFITS FROM PRIOR SYSTEMS:

The applicant may elect to receive the following benefits because of membership in a prior retirement system in lieu of the above. (A.R.S. 38-854) . . . . $ ____________________

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 or Secretary

---

ELECTION AND ACCEPTANCE BY MEMBER OR SURVIVOR
(Initial the appropriate line below)

(Initial)

____ I ELECT TO ACCEPT the type of pension benefit reflected above as well as the amount of benefits as determined under ITEM 1 above, representing the benefits payable to me and to my survivors under the Public Safety Personnel Retirement System.

____ I ELECT TO RECEIVE the benefits under ITEM 2 in accordance with the prior retirement system designated as____.

I UNDERSTAND that this election to receive benefits pursuant to this document and under the PSPRS or another system may not be revoked and is binding upon me or any beneficiary or survivor unless otherwise provided by law.

_____/_____/_____ Date

______________________________________ Signature of Member, Survivor or Guardian

______________________________________ Witness Signature

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) ☐Retired ☐Survivor/Guardian ☐Ex-spouse ☐Refunding

RETIREE SYSID (if known)	Date of Birth (MM/DD/YYYY)	Gender (Check One) ☐Male ☐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 # (9 digits): ______________________

Account # : ______________________

Financial Institution: ______________________

Routing # and account # samples:

⑆089400988⑆ 00149843⑈ 1438
ROUTING NUMBER / ACCOUNT NUMBER / CHECK NUMBER

⑆089400988⑆ 1438 3910 409843⑈
ROUTING NUMBER / CHECK NUMBER / ACCOUNT NUMBER

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."

ARIZONA FORM
A-4P

Annuitant's Request for Voluntary Arizona Income Tax Withholding

2012

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.

Form **W-4P**

Department of the Treasury
Internal Revenue Service

Withholding Certificate for Pension or Annuity Payments

OMB No. 1545-0074

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.

Form **W-4P**

Department of the Treasury
Internal Revenue Service

Withholding Certificate for Pension or Annuity Payments

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

OMB No. 1545-0074

2012

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.) . . . . ▶ ______ (Enter number of allowances.)

Marital status: ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate

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: { $11,900 if married filing jointly or qualifying widow(er); $8,700 if head of household; $5,950 if single or married filing separately } . . . **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 *Converting Credits to Withholding Allowances for 2012 Form W-4* 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

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
$0 - $5,000	0	$0 - $8,000	0
5,001 - 12,000	1	8,001 - 15,000	1
12,001 - 22,000	2	15,001 - 25,000	2
22,001 - 25,000	3	25,001 - 30,000	3
25,001 - 30,000	4	30,001 - 40,000	4
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		

Table 2

Married Filing Jointly		All Others	
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 - $70,000	$570	$0 - $35,000	$570
70,001 - 125,000	950	35,001 - 90,000	950
125,001 - 190,000	1,060	90,001 - 170,000	1,060
190,001 - 340,000	1,250	170,001 - 375,000	1,250
340,001 and over	1,330	375,001 and over	1,330

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.