

**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
_____	/	/	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 2<sup>nd</sup> 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:

<input type="checkbox"/> (a) None	Missed Pay Periods	Employer
<input type="checkbox"/> (b)	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

**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 2<sup>nd</sup> 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:

<input type="checkbox"/> (a) None	Missed Pay Periods	Employer
<input type="checkbox"/> (b)	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

**FORM P5-EE**

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**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
<input type="checkbox"/>	Spouse	<input type="checkbox"/>	Not applicable					
<input type="checkbox"/>	Child	<input type="checkbox"/>	Not applicable					
<input type="checkbox"/>	Child							
<input type="checkbox"/>	Child							

**APPLICATION FOR DISABILITY RETIREMENT**  
**Completed by Employee**

**REQUIRED AUTHORIZATIONS AND UNDERSTANDING – Initial the following:**

\_\_\_\_\_ I authorize and request each physician and person in the medical or related fields, and each hospital, clinic, establishment and place rendering or having in the past rendered to me any medical or related service to allow the Local Board, the office of the Board of Trustees of the 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

**PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM**

**FORM P5-LB**

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

08/11

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

**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  Working Part-time  Not Working  Regular Assignment  Limited Duty  Paid Leave  Unpaid 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**

**FORM P5-LB-A**

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**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.		<b>LOCAL BOARD Initial Response</b>	
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 <b>employer</b> terminate the employee's employment based on a physical or mental condition?		YES	NO
7. Did the <b>employer</b> terminate the employee's employment based on a disciplinary issue?		YES	NO
8. Did the <b>member</b> terminate employment based on a physical or mental condition?		YES	NO
9. Did the <b>member</b> 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
<b>LOCAL BOARD INSTRUCTIONS:</b> 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 <b>ORIGINAL</b> (along with the all medical evidence and any additional questions) to the doctor.			
<b>DOCTOR INSTRUCTIONS:</b> In addition to the IME report, answer the following questions, sign/date and return the <b>ORIGINAL</b> to the Local Board. Provide additional comments in the IME report.		<b>DOCTOR Initial Response</b>	
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 <b>permanently</b> prevent the member from performing a reasonable range of duties within the employee's job classification?		YES	NO
4. Does the condition <b>totally</b> 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
<b>LOCAL BOARD:</b> If conflicts in the medical evidence, address if and how they were resolved in the Local Board meeting minutes. <b>LOCAL BOARD AND DOCTOR:</b> 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-O**

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

08/11

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**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.		<b>LOCAL BOARD Initial Response</b>	
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 <b>employer</b> terminate the member's employment based on a physical or mental condition that is being applied for?		YES	NO
7. Did the <b>employer</b> terminate the employee's employment based on a disciplinary issue?		YES	NO
8. Did the <b>member</b> terminate employment based on a physical or mental condition?		YES	NO
9. Did the <b>member</b> 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
<b>LOCAL BOARD INSTRUCTIONS:</b> 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 <b>ORIGINAL</b> (along with the all medical evidence and any additional questions) to the doctor.			
<b>DOCTOR INSTRUCTIONS:</b> In addition to the IME report, answer the following questions, sign/date and return the <b>ORIGINAL</b> to the Local Board. Provide additional comments in the IME report.		<b>DOCTOR Initial Response</b>	
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 <b>permanently</b> prevent the member from performing a reasonable range of duties within the employee's department?		YES	NO
4. Does the physical condition <b>totally</b> prevent the member from performing a reasonable range of duties within the employee's department?		YES	NO
5. Does the mental condition <b>permanently</b> prevent the member from engaging in any substantial gainful activity?		YES	NO
6. Does the mental condition <b>totally</b> 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
<b>LOCAL BOARD:</b> If conflicts in the medical evidence, address if and how they were resolved in the Local Board meeting minutes. <b>LOCAL BOARD AND DOCTOR:</b> 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-T**

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

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.		<b>LOCAL BOARD Initial Response</b>	
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 <b>employer</b> terminate the employee's employment based on a physical or mental condition?		YES	NO
5. Did the <b>employer</b> terminate the employee's employment based on a disciplinary issue?		YES	NO
6. Did the <b>member</b> terminate employment based on a physical or mental condition?		YES	NO
7. Did the <b>member</b> 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
<b>LOCAL BOARD INSTRUCTIONS:</b> 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 <b>ORIGINAL</b> (along with the all medical evidence and any additional questions) to the doctor.			
<b>DOCTOR INSTRUCTIONS:</b> In addition to the IME report, answer the following questions, sign/date and return the <b>ORIGINAL</b> to the Local Board. Provide additional comments in the IME report.		<b>DOCTOR Initial Response</b>	
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 <b>temporarily</b> prevent the member from performing a reasonable range of duties within the employee's department?		YES	NO
4. Does the condition <b>totally</b> 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
<b>LOCAL BOARD:</b> If conflicts in the medical evidence, address if and how they were resolved in the Local Board meeting minutes. <b>LOCAL BOARD AND DOCTOR:</b> 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**

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08/11

**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.		<b>LOCAL BOARD Initial Response</b>	
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 <b>employer</b> terminate the employee's employment based on a physical or mental condition?		YES	NO
5. Did the <b>employer</b> terminate the employee's employment based on a disciplinary issue?		YES	NO
6. Did the <b>member</b> terminate employment based on this physical condition?		YES	NO
7. Did the <b>member</b> 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
<b>LOCAL BOARD INSTRUCTIONS:</b> 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 <b>ORIGINAL</b> (along with the all medical evidence and any additional questions) to the doctor.			
<b>DOCTOR INSTRUCTIONS:</b> In addition to the IME report, answer the following questions, sign/date and return the <b>ORIGINAL</b> to the Local Board. Provide additional comments in the IME report.		<b>DOCTOR Initial Response</b>	
1. Does the member have the physical condition that is the basis for the disability application?		YES	NO
2. Does the physical condition <b>permanently</b> prevent the member from engaging in any gainful employment?		YES	NO
3. Does the physical condition <b>totally</b> 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
<b>LOCAL BOARD:</b> If conflicts in the medical evidence, address if and how they were resolved in the Local Board meeting minutes. <b>LOCAL BOARD AND DOCTOR:</b> 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

**FORM P7D**

08/11

Page 1 of 1

**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: (\_\_\_\_) \_\_\_\_-\_\_\_\_

<b>Enclose:</b>	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

**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
_____	____/____/____	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  
**SERVICE RETIREMENT BENEFIT CALCULATIONS**  
 A.R.S. Section 38-845

**FORM P11**  
 08/11  
 Page 1 of 1

**USE THIS PAGE FOR ALL SERVICE RETIREMENTS AND SURVIVING SPOUSE, GUARDIAN AND ELIGIBLE CHILD BENEFITS FOR DECEASED MEMBERS WHO WERE RECEIVING SERVICE RETIREMENTS**

Member Name \_\_\_\_\_ Employer \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

PRIOR SERVICE From: \_\_\_\_\_ Through: \_\_\_\_\_ = \_\_\_\_\_ Years  
 Less Non-Credited Service From: \_\_\_\_\_ Through: \_\_\_\_\_ = \_\_\_\_\_ Years

SERVICE DATES From: \_\_\_\_\_ Through: \_\_\_\_\_ = \_\_\_\_\_ Years

LENGTH OF CREDITED SERVICE: \_\_\_\_\_ Years \_\_\_\_\_ Days

AMOUNT OF FINAL CONTRIBUTION TO PSPRS: \$ \_\_\_\_\_ for Pay Period Ending \_\_\_\_\_

**A. COMPENSATION: List total compensation for the highest three consecutive years within the last twenty completed years of credited service (if periods of LWOP and/or Workers' Compensation are included, please indicate):**

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

**B. TOTAL AMOUNT of highest three consecutive Years..... \$ \_\_\_\_\_**

**C. AVERAGE MONTHLY COMPENSATION - LINE B ÷ 36 months: ..... \$ \_\_\_\_\_**

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

1. Line C x 50%..... \$ \_\_\_\_\_
2. PLUS 2% of Line C for each year of credited service over 20 years..... \$ \_\_\_\_\_
3. TOTAL MONTHLY BENEFIT: ..... \$ \_\_\_\_\_

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

1. Line C x 50%..... \$ \_\_\_\_\_
2. PLUS 2.5% of Line C for each year of credited service over 20 years (MAX – 12 years)..... \$ \_\_\_\_\_
3. TOTAL MONTHLY BENEFIT: ..... \$ \_\_\_\_\_

**F. For retirement with 20 years of service but less than 20 years of credited service:**

1. Line C x 50%..... \$ \_\_\_\_\_
2. MINUS 4% of Line F1 for each year of credited service under 20 years... \$ \_\_\_\_\_
3. TOTAL MONTHLY BENEFIT: ..... \$ \_\_\_\_\_

**G. Surviving Spouse or Guardian Benefit: 4/5 of Line D3, E3 or F3, whichever is applicable..... \$ \_\_\_\_\_**

**H. Eligible Child Benefit: 1/10 of Line D3, E3 or F3, whichever is applicable (MAX – 2 child shares)... \$ \_\_\_\_\_**

CALCULATED BY: \_\_\_\_\_ DATE: \_\_\_\_\_  
 PHONE NUMBER: ( ) - \_\_\_\_\_

**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 P11D**

08/11

Page 1 of 1

**DISABILITY RETIREMENT BENEFIT CALCULATIONS**

A.R.S. Section 38-845

**USE THIS PAGE FOR ALL DISABILITY RETIREMENTS; SURVIVING SPOUSE, GUARDIAN AND ELIGIBLE CHILD BENEFITS FOR DECEASED MEMBERS WHO WERE RECEIVING DISABILITY RETIREMENTS; AND SURVIVING SPOUSE, GUARDIAN AND ELIGIBLE CHILD BENEFITS FOR NON-RETIRED, DECEASED MEMBERS**

Member Name \_\_\_\_\_ Employer \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

PRIOR SERVICE From: \_\_\_\_\_ Through: \_\_\_\_\_ = \_\_\_\_\_ Years  
Less Non-Credited Service From: \_\_\_\_\_ Through: \_\_\_\_\_ = \_\_\_\_\_ Years

SERVICE DATES From: \_\_\_\_\_ Through: \_\_\_\_\_ = \_\_\_\_\_ Years

LENGTH OF CREDITED SERVICE: \_\_\_\_\_ Years \_\_\_\_\_ Days

AMOUNT OF FINAL CONTRIBUTION TO PSPRS: \$ \_\_\_\_\_ for Pay Period Ending \_\_\_\_\_

**A. COMPENSATION:** List total compensation for the highest three consecutive years within the last twenty completed years of credited service (if periods of LWOP and/or Workers' Compensation are included, please indicate):

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

**B. TOTAL AMOUNT of highest three consecutive years..... \$ \_\_\_\_\_**

**C. AVERAGE MONTHLY COMPENSATION - LINE B ÷ 36 months: ..... \$ \_\_\_\_\_**

**D. ACCIDENTAL DISABILITY BENEFIT:** (also to be used for non-retired, deceased active member with less than 20 years of credited service)

1. For member with less than 20 years of credited service:  
Line C x 50% ..... \$ \_\_\_\_\_

2. For member with 20 or more years of credited service:  
Enter amount calculated on reverse side for normal service retirement: ..... \$ \_\_\_\_\_

**E. TEMPORARY DISABILITY BENEFIT:** (50% of annual compensation received immediately prior to date disability was incurred ÷ 12): ..... \$ \_\_\_\_\_

**F. ORDINARY DISABILITY BENEFIT:** (Line C x 50% x years of credited service / 20) ..... \$ \_\_\_\_\_

**G. CATASTROPHIC DISABILITY BENEFIT:**

1. First sixty months: Line C x 90% ..... \$ \_\_\_\_\_

2. Reduce after first sixty months to the greater of Line C x 62.5% OR  
Line C x 50% PLUS 2.5% of Line C for each year of credited service over 25 years  
(MAXIMUM - 12 years) ..... \$ \_\_\_\_\_

**H. SURVIVING SPOUSE OR GUARDIAN BENEFIT:** (4/5 of Line D1 or D2, E, F, G1 or G2, whichever is applicable, except 100% of base pay (Line C) if member killed in the line of duty, less any amount payable under Line I: ..... \$ \_\_\_\_\_

**I. ELIGIBLE CHILD BENEFIT:** 1/10 of Line D1, D2, E, F, G1 or G2 whichever is applicable (MAXIMUM - 2 child shares): (The eligible child benefit for a Line of Duty Death is based on an Accidental Disability benefit) ..... \$ \_\_\_\_\_

**CALCULATED BY:** \_\_\_\_\_

**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

**FORM P12**

08/11

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**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:  Catastrophic  Temporary Disability  Normal Retirement  Accidental Disability  Deferred Annuity  Survivor  Ordinary Disability  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](http://www.psprs.com)  
(602) 255-5575

Form 13  
08/11

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

**Retired Fax**  
(602) 296-2369

**AUTHORIZATION TO START OR CANCEL DIRECT DEPOSIT**

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

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

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

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

Check only one:  Checking OR  Savings

Routing # and account # samples:

Routing # (9 digits): \_\_\_\_\_

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

Account #: \_\_\_\_\_

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

Financial Institution: \_\_\_\_\_

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

**SECTION 3 – Cancellation of Direct Deposit**

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

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

By my signature below, I authorize and understand that:

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

<b>REQUIRED Signature</b>	<b>Date</b>
---------------------------	-------------

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

For account information, visit our website at [www.psprs.com](http://www.psprs.com) under "Members Only."

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

**Annuitant's Voluntary Arizona Income Tax Withholding Options**

**Choose only one:**

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

Additional amount to be withheld per distribution \$ \_\_\_\_\_

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

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

**GENERAL INSTRUCTIONS**

**Who May Use Form A-4P**

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

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

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

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

**Where to Send Form A-4P**

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

**Duration of Voluntary Arizona Withholding Election**

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

**How to Terminate a Voluntary Arizona Withholding Election**

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

**Statement of Income Tax Withheld**

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

**Withholding Certificate for  
 Pension or Annuity Payments**

**2012**

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

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

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

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

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

**Personal Allowances Worksheet (Keep for your records.)**

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

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

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

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

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

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

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

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

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

**Withholding Certificate for  
 Pension or Annuity Payments**

**2012**

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

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

**Complete the following applicable lines.**

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

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

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

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

Your signature ► \_\_\_\_\_

Date ► \_\_\_\_\_

**Deductions and Adjustments Worksheet**

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

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

**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).

<b>1</b>	Enter the number from line G, page 1 (or from line 10 above if you used the <b>Deductions and Adjustments Worksheet</b> ) . . . . .	<b>1</b>	_____
<b>2</b>	Find the number in <b>Table 1</b> below that applies to the <b>LOWEST</b> paying pension or job and enter it here. <b>However</b> , 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” . . . . .	<b>2</b>	_____
<b>3</b>	If line 1 is <b>more than or equal to</b> 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. <b>Do not</b> use the rest of this worksheet . . . . .	<b>3</b>	_____
<b>Note.</b> If line 1 is <b>less than</b> 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.			
<b>4</b>	Enter the number from line 2 of this worksheet . . . . .	<b>4</b>	_____
<b>5</b>	Enter the number from line 1 of this worksheet . . . . .	<b>5</b>	_____
<b>6</b>	<b>Subtract</b> line 5 from line 4 . . . . .	<b>6</b>	_____
<b>7</b>	Find the amount in <b>Table 2</b> below that applies to the <b>HIGHEST</b> paying pension or job and enter it here . . . . .	<b>7</b>	\$ _____
<b>8</b>	<b>Multiply</b> line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . . .	<b>8</b>	\$ _____
<b>9</b>	<b>Divide</b> 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 . . . . .	<b>9</b>	\$ _____

**Table 1**

**Table 2**

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

## Additional Instructions

*Section references are to the Internal Revenue Code.*

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