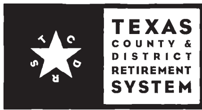


Disability Retirement Application

Please complete this form if you are applying for disability retirement from TCDRS. If you are eligible for service retirement, you do not need to complete this form. Instead, please apply for service retirement, which removes the need to go through the disability retirement approval process.

You'll also need to submit the following along with this form:

- The Physician's Statement on Disability (TCDRS-32)
- The Member's Statement on Disability (TCDRS-33)
- Medical records related to your disability
- Copy of your driver's license (or other government-issued photo ID)

YOUR INFORMATION

EMPLOYER NAME*			ACCOUNT NUMBER
SSN*	FIRST NAME*	MIDDLE NAME	LAST NAME*
MAILING ADDRESS*	CITY*	STATE*	ZIP*
EMAIL ADDRESS	HOME PHONE	MOBILE PHONE	

MARITAL STATUS

☐ Married ☐ Single

RETIREMENT DATE

Once your completed paperwork is received, the TCDRS Medical Board usually takes 4 to 8 weeks to determine eligibility for disability retirement. If your disability is approved, your first payment will be deposited into your account on the last business day of the month following your effective retirement date. For example, if your retirement date is in March, your first monthly benefit payment will be issued on the last day of April. Payment is only issued after the TCDRS Medical Board has approved your retirement. You have until 6 months after your retirement date to submit your retirement application for retroactive payments from the intended date.

MEMBER RETIREMENT DATE (MM/YYYY)*

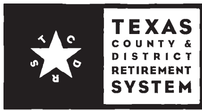
MONTHLY BENEFIT PAYMENT OPTIONS

All options provide you with a monthly payment for life. The difference between the options is the amount that is available for your beneficiary. Only check one box from the list below.

SINGLE LIFE PAYMENT OPTIONS	
☐ Single Life	This option provides the highest payment amount but all payments end after you pass away.
☐ 10-Year Guaranteed Term	Your beneficiary will only get payments if you pass away within 10 years of your retirement date.
☐ 15-Year Guaranteed Term	Your beneficiary will only get payments if you pass away within 15 years of your retirement date.
DUAL LIFE PAYMENT OPTIONS	
☐ 50% to Beneficiary	Your beneficiary will receive 50% of your monthly payment after you pass away.
☐ 75% to Beneficiary	Your beneficiary will receive 75% of your monthly payment after you pass away.
☐ 100% to Beneficiary	Your beneficiary will receive 100% of your monthly payment after you pass away.
☐ 100% to Beneficiary with Pop-up	Your beneficiary will receive 100% of your monthly payment after you pass away. If your beneficiary dies before you, your monthly payment will pop-up to the higher Single Life benefit amount.

*** REQUIRED FIELDS**

Any corrections or whiteouts must be initialed.



Disability Retirement Application

BENEFICIARY DESIGNATION

For the Single Life, 10-Year Guaranteed Term and 15-Year Guaranteed Term payment options, you can name as many beneficiaries as you would like and change your beneficiary at any time. Unless otherwise specified, benefits will be divided equally among all persons listed. If you are married and select one of these options, you'll need to complete the Spousal Consent section below.

For the 50%, 75%, 100% to Beneficiary and Pop-up options, you can only designate one beneficiary and cannot change your beneficiary. This is because these benefit amounts are based on your life expectancy and your beneficiary's life expectancy. If we cannot verify the age of your beneficiary, we will contact you.

PRIMARY BENEFICIARY

A primary beneficiary is the first person to receive any benefit that may remain after you pass away.

SSN*	FIRST NAME*	MIDDLE NAME	LAST NAME*
DATE OF BIRTH*	GENDER* ☐ MALE ☐ FEMALE	RELATIONSHIP TO YOU*	

SSN*	FIRST NAME*	MIDDLE NAME	LAST NAME*
DATE OF BIRTH*	GENDER* ☐ MALE ☐ FEMALE	RELATIONSHIP TO YOU*	

SSN*	FIRST NAME*	MIDDLE NAME	LAST NAME*
DATE OF BIRTH*	GENDER* ☐ MALE ☐ FEMALE	RELATIONSHIP TO YOU*	

ALTERNATE BENEFICIARY

An alternate beneficiary receives your benefit if your primary beneficiary is not eligible.

SSN*	FIRST NAME*	MIDDLE NAME	LAST NAME*
DATE OF BIRTH*	GENDER* ☐ MALE ☐ FEMALE	RELATIONSHIP TO YOU*	

SSN*	FIRST NAME*	MIDDLE NAME	LAST NAME*
DATE OF BIRTH*	GENDER* ☐ MALE ☐ FEMALE	RELATIONSHIP TO YOU*	

SPOUSAL CONSENT

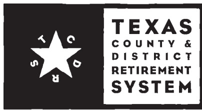
If you are married, your spouse's consent is needed if you selected a Single Life payment option or named someone other than your spouse if you selected a Dual Life payment option.

I certify that I am the spouse of the member. I understand that I have the right to be named as the sole beneficiary under a benefit option that would pay me a benefit for my lifetime. Nonetheless, I hereby give up my right to a lifetime benefit and give my consent to the option selection shown on this form and/or the beneficiary designation.

Spouse Signature	Date
X	

*** REQUIRED FIELDS**

Any corrections or whiteouts must be initialed.



Disability Retirement Application

INCOME TAX WITHHOLDING

Your benefit payments are considered taxable income. If you choose not to withhold taxes or don't withhold enough, you may have to pay a tax penalty to the IRS. If you need help choosing a withholding amount, please talk to a tax professional or contact the IRS. You may change your tax withholding at any time.

☐ **Option 1:** Please withhold according to IRS withholding tables:

Marital Status: ☐ Married ☐ Single ☐ Married, but withhold at higher single rate

Number of Personal Exemptions: __________

(Optional): Please withhold the following extra amount from each monthly payment: $__________

☐ **Option 2:** Do not withhold income tax from my monthly payment.

DIRECT DEPOSIT AUTHORIZATION

Your monthly benefit payment will be directly deposited into your bank account on the last business day of each month.

FINANCIAL INSTITUTION*	ROUTING NUMBER*	ACCOUNT NUMBER*	ACCOUNT TYPE*
			☐ Checking ☐ Savings

TERMS OF DISABILITY RETIREMENT

Please certify you understand the terms of your disability retirement.

If you have not yet attained service retirement eligibility or the age of 60, your benefit may be discontinued under the following circumstances:

- Refusal to undergo a medical examination if required by our Medical Board; or
- Your condition improves to the extent that you can engage in any gainful occupation.

I cannot change my benefit payment option after I start receiving benefits. I certify that my selection on this form is the benefit payment option I have chosen.

I understand that upon my retirement date all previous beneficiary designations, including those for Group Term Life benefits (if applicable), are revoked and the beneficiaries named in this application will be effective. I request that any payments due upon my death after retirement be paid to the person(s) named on this application. All benefits will be divided equally among beneficiaries if I named more than one unless otherwise noted.

For the financial account referenced above, I authorize the Texas County & District Retirement System (TCDRS) to deposit my monthly benefit payments electronically into my bank account. I also authorize TCDRS to make any adjustments to my account to correct any transactions made in error. This authorization shall remain in effect until I notify TCDRS to discontinue this payment method. I authorize the financial institution named above to disclose to TCDRS at any time my address and contact information, as well as the names and addresses of all joint owners, signatories, beneficiary or other persons associated with the above referenced account if I pass away.

I hereby make formal application for disability retirement benefits subject to a medical examination, review by the TCDRS Medical Board and approval by the TCDRS Board of Trustees.

Your Signature*	Date*
X	

Please return <u>all</u> pages of this form together to avoid processing delays.

*** REQUIRED FIELDS**

Any corrections or whiteouts must be initialed.