Public School Retirement System
of the City of St. Louis

Retirement Application

1. Please type or print in ink.
2. You MUST complete every section of this form.
3. You MUST sign and date Sections 2, 3, 4 and 5.
4. PSRSSTL must receive this Application AT LEAST 15 days prior to your Retirement Effective Date. Late receipt of this Retirement Application will cause your Retirement Effective Date to be delayed.
5. To obtain a quote under Benefit Payment Option 5, 6 or 7, you must provide an estimate from Social Security of your benefit amount at age 62.
6. The beneficiary designations you make on this Retirement Application will replace any designations on file with PSRSSTL effective on your Retirement Effective Date.

Section 1: Personal Information

Your Name:			Sex: Male ☐ Female ☐
Street Address:			Marital Status:
Address 2:			Birth Date:
City:			Age at Retirement:
State:	Zip:		Work Phone:
Soc. Sec. No.:	Personnel No:		Home Phone:
Job Title:			
Employment Type:	10 month ☐	10.5 month ☐	11 month ☐ 12 month ☐

Section 2: Application for Pension Benefits

Enter the last day for which you expect to be paid by your employer (include salary, sick leave, etc.):	
Enter the last day that you expect to work at your employer (not the last day that you expect to be paid):	
Enter the effective date of your retirement (must be "beginning of day" the first day of a month.):	
Your signature:	Date of signature:

Section 3: Benefit Payment Options

☐ I **DO NOT** elect a benefit payment option.

If you check this box, you must sign and date below and initial here: ☐

☐ I **DO** elect a benefit payment option.

I understand that if I elect to receive my retirement benefits under one of the survivor payment options described below, my benefits will be reduced in order to provide monthly payments to my option beneficiary after my death. I understand that I may not change my payment option or my option beneficiary after my retirement benefit payments begin. I also understand that if I select one of the survivor payment options below, I must provide PSRSSTL with a copy of the birth certificate and Social Security card of my option beneficiary at least 15 days prior to my retirement effective date.

Place a check mark in the appropriate box to indicate the Payment Option you are electing. Provide Option Beneficiary information and sign and date below.

☐ Option 1	If the Option Beneficiary I have designated below is still living at the time of my death, my reduced monthly benefit payments shall continue to my Option Beneficiary on a monthly basis for his/her lifetime.
☐ Option 2	If the Option Beneficiary I have designated below is still living at the time of my death, half of the amount of my reduced monthly benefit payments shall continue to my Option Beneficiary on a monthly basis for his/her lifetime.
☐ Option 3	The same as Option 1, except that, if my Option Beneficiary dies before I do, effective the first day of the month following my Option Beneficiary's death, my reduced monthly benefit will be increased to the amount I would have received at the time of my retirement had I not elected this Benefit Payment Option.
☐ Option 4	The same as Option 2, except that, if my Option Beneficiary dies before I do, effective the first day of the month following my Option Beneficiary's death, my reduced monthly benefit will be increased to the amount I would have received at the time of my retirement had I not elected this Benefit Payment Option.
☐ Option 5	My monthly benefit prior to age 62 shall be increased so that my pension prior to age 62 shall be approximately equal to the sum of my pension after age 62 plus my estimated federal Social Security benefit.
☐ Option 6	My monthly benefit shall be a combination of Benefit Payment Option 1 and Benefit Payment Option 5.
☐ Option 7	My monthly benefit shall be a combination of Benefit Payment Option 2 and Benefit Payment Option 5.

Name of Option Beneficiary:	Option Beneficiary's Social Security Number:	
Relationship:	Option Beneficiary's Date of Birth:	
Street Address:		
Address 2:		
City:	State:	Zip:
Your signature:	Date of signature:	

Office Use Only: Eligibility Determined _____ Verified _____ To Ins. Dept._____

Section 4: Beneficiary Designation

Designation of beneficiary is for any unpaid contributions to the System only. Member contributions are paid out first when retirement benefits begin and are typically exhausted within 2-3 years of retirement. This designation does not provide a monthly retirement benefit to the beneficiary after Member's death.

Primary Beneficiary(ies)		
Name:	Relationship:	
Soc. Sec. No.:	Date of Birth:	
Street Address:		
Address 2:		
City:	State:	Zip:

Name:	Relationship:	
Soc. Sec. No.:	Date of Birth:	
Street Address:		
Address 2:		
City:	State:	Zip:

Name:	Relationship:	
Soc. Sec. No.:	Date of Birth:	
Street Address:		
Address 2:		
City:	State:	Zip:

Contingent Beneficiary(ies)		
Name:	Relationship:	
Soc. Sec. No.:	Date of Birth:	
Street Address:		
Address 2:		
City:	State:	Zip:

Name:	Relationship:	
Soc. Sec. No.:	Date of Birth:	
Street Address:		
Address 2:		
City:	State:	Zip:

Section 5: Health Care Insurance Information

You may only enroll for PSRSSTL-sponsored insurance (1) upon your retirement, (2) during the open enrollment period immediately following your eligibility for Medicare Part A & B, or (3) within thirty days of your involuntary loss of other group coverage. Enrollment form and benefit information about the PSRSSTL available insurance programs are included in this retirement packet, which starts on Page 19. If you would like to enroll in PSRSSTL sponsored benefits, please complete the Benefit Enrollment Form found on Page 63.

Medical Insurance

As of your retirement date, will you or any of the dependents you wish to enroll for medical insurance be entitled to Medicare insurance benefits due to age or disability status with the Social Security Administration? Yes ☐ No ☐

Medicare-entitled members and dependents must have both Part A and Part B coverage to be eligible to enroll for PSRSSTL insurance.

Provide the name of the medical plan under which you are currently covered through St. Louis Public Schools.

Your Signature: Date of Signature:
