

Rev. 03/01

Complete and Mail to: Public Employees' Retirement System of Mississippi
 429 Mississippi Street, Jackson, MS 39201-1005
 1-800-444-7377 • (601) 359-3589 • Fax: (601) 359-2865 • www.pers.state.ms.us

Must be completed within 3 months before retirement date. Benefits will be effective the first of the month after PERS receives this completed form, but no earlier than the first of the month after termination. Attach completed PERS Form 9F, Family Information. If applying for disability benefits, attach completed PERS Form 8, Medical Information Form.

Section 1: Retirement Plan

Select One (Please Print in Black Only)

PERS SLRP MHSPRS MUNI (City) _____

Projected Date of Retirement ____|____|____ (Each employer must complete Part 2, Employment and Wage Certification Form)
MONTH DAY YEAR

Section 2: Retirement Type

Select Only One

<input type="checkbox"/> Service Retirement (Never Retired)		Date of First Retirement: ____ ____ ____
<input type="checkbox"/> Recalculation of Benefits after Retiree Reemployment in Excess of 6 Months		
Disability (Select One)		
<input type="checkbox"/> Duty Related Disability (Hurt on the job)	<input type="checkbox"/> Non-Duty Related Disability	Number of Dependent Children _____ (Applicable for PERS Tiered Disability Benefits or Spouse/Dependent Child Benefits of all Plans. Attach Proofs of birth for Spouse/Child.)
Spouse Survivor/Dependent Child Benefits (Select One)		
<input type="checkbox"/> Duty Related Death (Member killed on the job)	<input type="checkbox"/> Non-Duty Related Death	
Member's Date of Death: ____ ____ ____		

Section 3: Level Option 4C Information (Optional - Refer to Member Handbook or PERS Website at www.pers.state.ms.us for more information.)
(Applies to PERS, SLRP, MHSPRS Service Retirement Only. Does Not Apply to MUNI)

If under age 62 and you would like a benefit calculation under the provisions of the Level Option 4C, attach a copy of your Social Security Estimate which must be dated no earlier than 6 months from your projected date of retirement. You may contact Social Security at 1-800-772-1213. A Social Security Estimate is not attached but will be mailed to PERS.
 A Social Security Estimate is attached.

Section 4: Member Information (Attach Proof of Birth for Member)

First Name	MI	Last Name
Social Security Number	Date of Birth	
Address:	Home Phone	Business Phone
City:	State:	Zip:

Section 5: Beneficiary Information For Use as Joint Annuitant In Calculation of Benefit Estimates Under Service And Disability Retirement (Attach Proof of Birth for Each Beneficiary Listed)

For PERS, SLRP and MHSPRS Only. This will not be used to change the beneficiary designation on your account. FOR ESTIMATE ONLY. Name two (2) beneficiaries if you want to review an estimate under Option 3.

First Name of Beneficiary	MI	Last Name
Relationship	Social Security Number	Date of Birth

For Option 3 Estimate:

First Name of 2nd Beneficiary	MI	Last Name
Relationship	Social Security Number	Date of Birth

Section 6: Authorization of Benefit Applicant

X
 Signature of Applicant or Authorized Representative _____ Date of Signature _____

If an Authorized Representative signs this form, attach a copy of the Durable Power of Attorney, Conservatorship or Guardianship papers, or other legal documents as proof of authority to sign this form.

LEGAL DOCUMENTS ATTACHED.

Application for Retirement Benefits Employment and Wage Certification

Complete and Mail to: Public Employees' Retirement System of Mississippi
429 Mississippi Street, Jackson, MS 39201-1005
1-800-444-7377 • (601) 359-3589 • Fax: (601) 359-2865 • www.pers.state.ms.us

Must be completed and returned to PERS by all employers within three months before the applicant's date of retirement. This information is used to calculate the benefit payable at retirement. This will be the only time this information will be requested. The employer may submit a corrected Employment and Wage Certification Form if there is a change in the number of unused leave days, the amount of lump sum leave payment and/or monthly wages at the time of actual termination of employment. If necessary to correct the information, mark "corrected/changed". Enter the member's name, SSN and complete only those sections to be corrected.

Section 1: (Select One) **Original Certification** **Corrected/Changed Certification**

Section 2: Retirement Plan **PERS** **SLRP** **MHSPRS** **MUNI (City)** _____

Member's First Name MI Last Social Security Number Date of Birth

Section 3: Member's Position Title _____

Elected Official: Yes No **Fee Paid Official:** Yes No

Is member employed by any other covered agency? Yes No If yes, list: _____
(If yes, each employer **must** complete a separate Employment and Wage Certification Form.)

Section 4: **Complete if Duty-Related Disability or Death Claim** (Attach Copy of Worker's Compensation Report)
 I certify that an accident or injury occurred in the performance of duty causing this claim to be filed.
 I **Do Not** certify that an accident or injury occurred in the performance of duty.

Section 5: If Disability Claim, complete and attach PERS Form 6B, Employer's Certification of Job Requirements.

Section 6: Date of Termination: ____/____/____ Last Pay Date: ____/____/____

Section 7: Date of Last Wage and Contribution Report to be Submitted: MM/DD ____/____

Section 8A: **Projection of Unreported Wages for PERS, SLRP and MHSPRS plan members**
Project all unreported wages from the month this application is completed through the month the last wage and contribution report will be submitted for this employee as indicated in Section 7, above. For members who are Elected Officials and will receive Elected Official Unused Leave, please work with the employee to provide a listing of all dates of elected service and offices held.

Month/Year	Wages

Lump Sum Leave Payment: \$ _____

Elected Official Service Dates Attached.

Number of Unused Uncompensated Personal and Major Medical Leave Days _____

(DO NOT Submit PERS Form 18)
Form 18 is to be used for members terminating for reasons other than retirement.

Section 8B: **Certification of Wages for MUNI** (For use with members of the General Municipal and the Fire/Police Disability and Relief Funds ONLY.)
Certify the base salary and longevity pay received in consecutive pay periods immediately preceding retirement. List amounts paid during the last six (6) months of employment, or the equivalent pay periods if the employee is paid bi-weekly or semi-monthly. Certify only holiday pay earned for holidays occurring during the last six (6) months of employment.

Pay Periods	Wages

Pay Periods	Wages

Pay Periods	Wages

Lump Sum Leave Pay (If Applicable): \$ _____ **Number of Unused Uncompensated Leave Days (If Applicable)** _____

Section 9: **Certification of Increases in Salary or Compensation.** (Complete ONLY if PERS Member's Salary has increased in excess of 8% annually during the 24 month period prior to the effective date of retirement.) Check the space(s) that apply.

I certify that this member's salary increase was authorized: as a result of a position change, OR as provided under State Personnel Board rules, OR under statutory enactment (Cite Statutory Provision: _____), none of the above. I certify this salary increase was or was not provided contingent upon a promise or agreement to retire.

Section 10: Employer Certification

X
Signature of Authorized Employer Representative Title Agency Name Date Telephone Number

Family Information Form
Complete and Attach to PERS Form 9A

Mail to: Public Employees' Retirement System of Mississippi
429 Mississippi Street, Jackson, MS 39201-1005
1-800-444-7377 • (601) 359-3589 • Fax: (601) 359-2865 • www.pers.state.ms.us

Please make as many copies
of this form as needed,
numbering each one.

ALL applicants for monthly benefits MUST complete this form. The information will be used as a reference by PERS in determining eligibility for benefits in the event of the death of the member and/or beneficiary of the member, as provided by law.

Name of Member

First	MI	Last Name	
Social Security Number		Date of Birth	

Name of Spouse

First	MI	Last Name	
Social Security Number	Date of Birth	Telephone Number: Home	Work
Address			
City	State		Zip

Child Information

First Name	<input type="checkbox"/> Dependent	<input type="checkbox"/> Not Dependent	MI	Last Name
Social Security Number	Date of Birth			
Address				
City	State			Zip

Relationship to the Member: Biological Child Adopted Step Child Legal Custody (Attach Copy of Legal Documents)
Provide the Name, Address and Telephone Number of the Parent or Guardian responsible for the Child:

Child Information

First Name	<input type="checkbox"/> Dependent	<input type="checkbox"/> Not Dependent	MI	Last Name
Social Security Number	Date of Birth			
Address				
City	State			Zip

Relationship to the Member: Biological Child Adopted Step Child Legal Custody (Attach Copy of Legal Documents)
Provide the Name, Address and Telephone Number of the Parent or Guardian responsible for the Child:

Child Information

First Name	<input type="checkbox"/> Dependent	<input type="checkbox"/> Not Dependent	MI	Last Name
Social Security Number	Date of Birth			
Address				
City	State			Zip

Relationship to the Member: Biological Child Adopted Step Child Legal Custody (Attach Copy of Legal Documents)
Provide the Name, Address and Telephone Number of the Parent or Guardian responsible for the Child:

Family Information Form
(Additional Listings)

Mail to: Public Employees' Retirement System of Mississippi
429 Mississippi Street, Jackson, MS 39201-1005
1-800-444-7377 • (601) 359-3589 • Fax: (601) 359-2865 • www.pers.state.ms.us

Please make as many copies
of this form as needed,
numbering each one.

Name of Member

First MI Last Name

Social Security Number Date of Birth

Child Information

Dependent Not Dependent

First Name MI Last Name

Social Security Number Date of Birth

Address

City State Zip

Relationship to the Member: Biological Child Adopted Step Child Legal Custody (*Attach Copy of Legal Documents*)
Provide the Name, Address and Telephone Number of the Parent or Guardian responsible for the Child:

Child Information

Dependent Not Dependent

First Name MI Last Name

Social Security Number Date of Birth

Address

City State Zip

Relationship to the Member: Biological Child Adopted Step Child Legal Custody (*Attach Copy of Legal Documents*)
Provide the Name, Address and Telephone Number of the Parent or Guardian responsible for the Child:

Child Information

Dependent Not Dependent

First Name MI Last Name

Social Security Number Date of Birth

Address

City State Zip

Relationship to the Member: Biological Child Adopted Step Child Legal Custody (*Attach Copy of Legal Documents*)
Provide the Name, Address and Telephone Number of the Parent or Guardian responsible for the Child:

Employer's Certification of Job Requirements

Public Employees' Retirement System of Mississippi
429 Mississippi Street, Jackson, MS 39201-1005
1-800-444-7377 · (601) 359-3589 · Fax: (601) 359-2865 · www.pers.state.ms.us

(15. Continued from other side) Describe employee's exposure to marked changes in temperature and humidity.

(16. Continued from other side) Specify tools/equipment used by employee.

H. Is the employee allowed to change positions, i.e. from sitting to standing, standing to sitting? YES NO

If so, how often: _____

I. Can the employee vary his/her work schedule as often as needed? YES NO

J. In your opinion, can the employee perform his/her job? YES NO

If NO, what specific duties performed or expected of the employee are impaired by the employee's alleged disability?

K. Does the employee appear to be motivated toward continuing current employment? YES NO

L. Has the employee been offered another job within your agency or any other agency covered by the Public Employees' Retirement System without a material reduction in compensation or change in location of employment? YES NO

IF YES, DESCRIBE JOB AND DUTIES:

M. Describe accommodations, if any, offered or provided the employee to allow him or her to continue gainful employment with your agency.

N. Certify the number of days this employee has been absent from work due to the disability for which benefits are being claimed during the 12 month period immediately preceding termination, leave of absence, or application for disability, whichever applies.

I CERTIFY THE ABOVE AND FOREGOING STATEMENTS ARE CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT THIS AGENCY HAS COMPLIED WITH ALL APPLICABLE PROVISIONS OF THE AMERICANS WITH DISABILITIES ACT, INCLUDING BUT NOT LIMITED TO, PROVISIONS TO MAKE REASONABLE ACCOMMODATIONS TO ALLOW THIS EMPLOYEE TO REMAIN ON THE JOB.

X

Print Name:

Signature of Certifying Official
who has first hand knowledge of the job duties.

Date

Title

Address

Telephone Number

City

State

Zip

APPLYING FOR DISABILITY RETIREMENT BENEFITS

The disability application process requires the participation and cooperation of your employer, your treating physicians, representatives from the hospitals in which you have been treated, as well as the assistance of your PERS Disability Benefit Analyst. The application process normally takes at least 2-3 months after PERS has received the completed application, including the PERS Form 6B, Employer's Certification of Job Requirements, PERS Form 8, Medical Information Form, the completed benefit payment selection forms and copies of all medical records for review by the PERS Medical Board. The Disability Analyst will notify you of the information received and the information needed before your claim can be presented to the PERS Medical Board. Your claim will not be presented to the PERS Medical Board until all of the necessary employment and medical information has been received. The PERS Medical Board normally meets once each month. The decisions of the PERS Medical Board are provided to you in writing. PERS staff are not allowed to provide information about the decision over the phone.

Employment Information

A key factor in determining eligibility for disability benefits is comparison of the physical and mental requirements of the job to the documented functional limitations of the medical condition for which benefits are being claimed. The employer plays a key role in the disability determination process by providing detailed and accurate information about the applicant's job requirements.

The employer must also certify whether or not alternative employment opportunities have been made available to the applicant. By law, the employer is required to certify whether or not reasonable accommodations, as required under the Americans with Disabilities Act (ADA), have been made available to the applicant.

Medical Information

In completing the PERS Form 8, Medical Information, the applicant must provide information about the job requirements and the duties that cannot be performed as a result of the alleged disability for which benefits are being claimed. A complete listing of all treating physicians and hospitals must be provided as a reference in determining the information you plan to submit for review by the PERS Medical Board. It is very important to submit current medical information. The medical information you elect to submit must be detailed and thorough. Be sure to submit copies of all of the results of any special tests, including x-rays, MRIs, laboratory tests and blood work to serve as an objective measure of the existence of the medical condition for which benefits are being claimed. The more information available to the PERS Medical Board, the better. You are advised to submit copies of medical records reflecting your medical condition and history of treatment over the past 3 years.

Disability Determination

The PERS Medical Board is charged with determining an applicant's eligibility for benefits. This determination is based upon a review of the employment and medical information contained in the applicant's record. The Medical Board must determine whether or not sufficient, objective medical evidence exists to support a decision that the medical condition for which benefits are applied permanently and totally prohibit the applicant from performing the job requirements, as described by the employer. The applicant must provide evidence to support that the termination from covered employment was due to the alleged disability and not for some other reason. A medical condition that prohibits one from performing the essential functions of the job but that is not likely to be permanent, will not be approved for benefits. If a member delays in filing a claim, the Medical Board must determine whether or not the applicant met the requirements for benefits at the time of termination from covered employment.

Upon review of the medical record provided by the applicant, the PERS Medical Board may request additional information and/or request the applicant be evaluated by a physician of their choice. In such cases, PERS will pay for the evaluation in accordance with the fee schedule approved by the PERS Board of Trustees. In some cases, the applicant may be required to travel to Jackson or another town to obtain the additional evaluation required by the Medical Board. Every effort will be made by staff to refer an applicant to a treatment facility within a reasonable distance from the place of residence. However, this is not always possible. Be aware, PERS does not reimburse an applicant for travel expenses incurred.

A favorable determination of disability from the Social Security Administration or other agency providing disability benefit coverage does not result in an automatic approval of benefits under PERS. This information will be considered by the PERS Medical Board, if submitted during the claims review process. However, the criteria for benefit eligibility from PERS is unique to PERS and separate from any other disability benefit coverage plan.

PERS Medical Board Decisions

The PERS Medical Board, consisting of 3 physicians practicing in specialized fields of medicine, have three alternatives in determining an applicant's eligibility for benefits. The Medical Board may approve a claim, deny a claim, or defer a decision, requesting additional information or an evaluation or special test from a physician or treating facility of their choice. The PERS Disability Analyst will notify the applicant, in writing, of the decision of the Medical Board. If approved, the Disability Analyst will process the claim to payroll. If deferred, the Disability Analyst will contact the referral resource and schedule a preliminary date for the evaluation. The applicant will then be notified in writing of the PERS Medical Board recommendation, including the date, time and location of any evaluation. If the applicant is unable to keep the appointment PERS must be notified in advance so that an appointment can be rescheduled as soon as possible. If the claim is denied, a notice of such decision will be forwarded, in writing, along with a listing of alternatives for action by the applicant, including filing a Notice of Appeal of the PERS Medical Board decision. A member has 60 days from the date of receipt of the Notice of Decision, to file a Notice of Appeal.

Rev. 7/00

Public Employees' Retirement System of Mississippi
429 Mississippi Street, Jackson, MS 39201-1005
1-800-444-7377 • (601) 359-3589 • Fax: (601) 359-2865 • www.pers.state.ms.us

Section 1

Select One (Please Print in Black Only)

PERS **SLRP** **MHSPRS** **MUNI** (City) _____

Name _____ Social Security Number _____ Date of Birth _____

Highest Level of Education

(Circle One) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Section 2

a) What is your disability?

b) When did your disability first prevent you from performing required job duties? Month Date Year

c) If no longer working, explain why you stopped working:

d) Current employment status: Leave without pay Leave with pay Working Terminated Date ___/___/___

Section 3

List the names, addresses and telephone numbers of the physicians who have treated you for the last 3 - 5 years:

Physician's name _____ Medical Specialty (e.g., cardiology, psychiatry, etc.) _____

Address _____ Telephone Number _____

How often did you see this physician?

Date first seen _____ Date last seen _____

Reason for visits/treatments received _____

Physician's name _____ Medical Specialty (e.g., cardiology, psychiatry, etc.) _____

Address _____ Telephone Number _____

How often did you see this physician?

Date first seen _____ Date last seen _____

Reason for visits/treatments received _____

Rev. 7/00

Public Employees' Retirement System of Mississippi
429 Mississippi Street, Jackson, MS 39201-1005
1-800-444-7377 • (601) 359-3589 • Fax: (601) 359-2865 • www.pers.state.ms.us

Physician's name _____ Medical Specialty (e.g., cardiology, psychiatry, etc.) _____

Address _____ Telephone Number _____

How often did you see this physician? _____

Date first seen _____ Date last seen _____

Reason for visits/treatments received _____

If more than 3 treating physicians, attach separate list _____

If you have additional physicians that might contribute medical information to support your disability, please attach a separate sheet, listing information requested above. Check here if additional listings attached.

Section 4

If you have been hospitalized during the past 3-5 years on an inpatient, outpatient or emergency basis, please provide information below:

Hospital name and address

Inpatient Outpatient Admission Date _____ Discharge Date _____

Describe the reason for your stay and the treatment you received. Please state any special testing including x-rays, MRI, etc. performed while you were in the hospital. _____

Hospital name and address

Inpatient Outpatient Admission Date _____ Discharge Date _____

Describe the reason for your stay and the treatment you received. Please state any special testing including x-rays, MRI, etc. performed while you were in the hospital. _____

Hospital name and address

Inpatient Outpatient Admission Date _____ Discharge Date _____

Describe the reason for your stay and the treatment you received. Please state any special testing including x-rays, MRI, etc. performed while you were in the hospital. _____

Section 5

Have you been to other agencies for evaluation or to file a claim for disability benefits? Yes No

(For example, Veterans Administration, Workers' Compensation, Vocational Rehabilitation, Social Security Administration)

1) If yes, Name of Agency _____
Date Filed for Benefits _____ Date Approved _____ Date Denied _____ Pending _____

2) If yes, Name of Agency _____
Date Filed for Benefits _____ Date Approved _____ Date Denied _____ Pending _____

3) If yes, Name of Agency _____
Date Filed for Benefits _____ Date Approved _____ Date Denied _____ Pending _____

Section 6

List of current medications: (Provide name of drug, dose, how often taken, and how long you have been taking this medication.)

Section 7

Does your doctor restrict your activities in any way? Yes No

If yes, which doctor?

State what the physician told you not to do:

Section 8

Has your disability affected your home duties, social activities, or your ability to care for your personal needs? Yes No

If Yes, please describe what you cannot do:

Section 9

1. How long have you been employed in the job for which benefits are being claimed?

2. If less than four (4) years, what other jobs have you held? List your job title, your employer's name(s), and how long you were employed:

3. Are you currently employed in another position not covered under the Public Employees' Retirement System? Yes No

If yes, list your job title and your employer's name and how long you have been employed there:

4. Have you ever been given permanent restrictions related to any job-related injury? Yes No

5. Have you ever been assigned a permanent partial impairment or worked under restrictions? Yes No

6. Do you smoke? Yes No

7. Have you ever filed or been treated for a Worker's Compensation Claim? Yes No

If yes, provide dates: _____

I certify that all of the preceding information is true and complete to the best of my knowledge:

X
Applicant's Signature

Date