

## Retirement Application

This application is for retirement from the Arkansas Teacher Retirement System (ATRS). If eligible, you will receive a monthly retirement benefit from ATRS for your lifetime. You must meet all eligibility requirements and submit a fully completed retirement application to ATRS at least one (1) month prior to the proposed effective date of retirement in order to receive benefits on your selected date.

### Member Information

Name (Last, First, Initial) \_\_\_\_\_

SSN \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mobile Phone (\_\_\_\_) \_\_\_\_\_ Alternate Number (\_\_\_\_) \_\_\_\_\_

Email Address \_\_\_\_\_

Do you now or will you ever draw a pension from another Arkansas public retirement plan other than Social Security?

☐ Yes ☐ No

If yes, what plan? \_\_\_\_\_

If you are a T-Drop participant, you must submit a T-Drop Distribution form with this application.

### Employer Information

Last date worked for your current employer \_\_\_\_\_

List all ATRS covered employers (including public colleges and universities) from which you have received salary in the prior 12 months.

\_\_\_\_\_

\_\_\_\_\_  
Member's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

## Retirement Annuity Options

Please select an annuity option for your monthly benefits: **(please check only one)**

- ☐ **Option 1 Straight Life Annuity** – This annuity option pays the maximum benefit payable to you each month for your lifetime based on your accrued benefits. All annuity benefits will cease upon your death. Any remaining balance of your accumulated contributions and interest will be paid to the surviving beneficiary in a lump sum. **Note:** If you have been married for less than one (1) year on your effective date of retirement, then certain rules will let you change your Straight Life Annuity to an Option A or Option B benefit after being married for one (1) full year. Contact ATRS for additional information.
- ☐ **Option A – 100% Survivor Annuity** – This annuity option pays a reduced benefit to you each month for life and continues to pay 100% of your monthly benefit to your eligible Option A beneficiary for his or her lifetime after your death.

Eligible Option A beneficiaries are your spouse if you have been married for at least 1 year prior to your effective date of retirement; and/or your dependent child, regardless of age, who has been declared mentally or physically incapacitated by a Court. If you have an incapacitated child, please contact our office.

Name of Option A 100% Beneficiary \_\_\_\_\_

Beneficiary Date of Birth \_\_\_\_\_ Relationship of Beneficiary to You \_\_\_\_\_

Address of Beneficiary \_\_\_\_\_

Please submit beneficiary's proof of age, copy of Social Security card, and a copy of your marriage license if option beneficiary is your spouse. Be sure to write your SSN on these documents so they can be placed correctly in your ATRS file.

- ☐ **Option B – 50% Survivor Annuity** - This annuity option pays a reduced benefit to you each month for life and continues to pay 50% of your monthly benefit to your eligible Option B beneficiary for his or her lifetime after your death.

Eligible Option B beneficiaries are your spouse if you have been married for at least 1 year prior to your effective date of retirement; and/or your dependent child, regardless of age, who has been declared mentally or physically incapacitated by a Court. If you have an incapacitated child, please contact our office.

Name of Option B 50% Beneficiary \_\_\_\_\_

Beneficiary Date of Birth \_\_\_\_\_ Relationship of Beneficiary to You \_\_\_\_\_

Address of Beneficiary \_\_\_\_\_

Please submit beneficiary's proof of age, copy of Social Security card, and a copy of your marriage license if option beneficiary is your spouse. Be sure to write your SSN on these documents so they can be placed correctly in your ATRS file.

- ☐ **Option C – 10 Year Certain Annuity** – This annuity option pays a reduced benefit to you for the first ten (10) years in equal, monthly payments. After ten (10) years, if you survive, then the monthly benefit will be payable in the maximum amount of the straight life benefit payable under Option 1 thereafter. If you die prior to receiving 120 monthly payments, your Option C beneficiary will receive your reduced benefit for the remainder of the 120 payments. Eligible Option C beneficiaries are any natural persons regardless of age or relationship to you.

Name of Option C 10-Year Beneficiary \_\_\_\_\_

Address of Beneficiary \_\_\_\_\_

\_\_\_\_\_  
Member's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

**Acknowledgment of Termination Requirements**  
**(not applicable for members who have reached normal retirement age)**

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*Normal Retirement Age* is defined as the age of 65 OR if the member is at least the age of 60 and the member's age and combined years of credited service total 98 or more. A member *must* terminate employment unless they meet the *Normal Retirement Age*. If you have not met the Normal Retirement age, you may not return to work for an ATRS covered employer for four (4) months from your effective date of benefits.

Federal and state laws require termination and a termination separation period for all members who have not reached *Normal Retirement Age*. If you have not reached *Normal Retirement Age* and fail to terminate employment by your effective date of retirement, become employed by an ATRS covered employer within the required separation period, or even have an agreement to return to work before or during your retirement separation period is complete, then you are not eligible to retire.

I state my understanding that during my termination separation period, I must sever and end all employer-employee relationships at all ATRS covered employers and my understanding that all the following apply:

- ☐ I cannot form any employment relationship with any ATRS covered employer;
- ☐ I cannot render any service for pay to or on behalf of any ATRS covered employer, with or without a contract
- ☐ **I cannot work for pay even for one day;**
- ☐ I understand that I cannot work either full or part time for any ATRS covered employer;
- ☐ I cannot exercise any authority to act as a representative of any ATRS covered employer;
- ☐ I cannot form any express or implied employment agreements, or take any action to or entitle any ATRS covered employer to my services until after my separation period has ended;
- ☐ I cannot provide volunteer activities for any ATRS covered employer that will have the effect of holding a position open for me (I can volunteer at an ATRS employer if it does not help hold a position open);
- ☐ I cannot have reached an agreement either before or during the termination period to work at an ATRS employer after the termination period;
- ☐ I understand that ATRS employers to which the termination separation period applies include all Arkansas public schools, educationally related state agencies, and **some colleges, universities and post-secondary institutions;**
- ☐ I understand that working for pay even for one day or **just for one hour** as a substitute or any other school employee is a violation of the termination separation period;
- ☐ I understand if I violate my termination requirements or my termination separation period, my retirement and benefits will be canceled, and I will be responsible for repaying all benefits back to ATRS;
- ☐ I understand that the termination and termination separation period are **strictly enforced** and unintentional violations still require total correction; and
- ☐ I verify that I will comply with the termination/separation requirements for retirement. I further verify that I have no express or implied agreement to be rehired or otherwise become employed by any ATRS covered employer as of the effective date of my retirement;

Retiree's Signature

Date

Social Security Number

- I understand my separation period begins on my effective date of retirement, which is always the 1<sup>st</sup> day of the month in which my benefits begin.  
**My separation period does not begin on the last day I worked for an ATRS covered employer.**
- I understand that if I am uncertain or have questions, I can call or contact ATRS and get clarification;
- I have read this Acknowledgment of Termination Requirements for and agree to comply with all requirements of the termination and termination separation period that apply to me.

**Verification**

I \_\_\_\_\_ (name of Retiree) swear or affirm that my statements contained in the above and forgoing Acknowledgment of Termination Requirements are true and correct to the best of my knowledge, information and belief.

\_\_\_\_\_  
Retiree's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

**To be completed by a Notary Public**

State of \_\_\_\_\_)

(Notary Seal)

County of \_\_\_\_\_)

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Signature

\_\_\_\_\_  
My Commission expires

## Federal and State Tax Election Form

**Payee Type:** ☐ Member ☐ Survivor ☐ Beneficiary ☐ QDRO Recipient • Member's SSN: \_\_\_\_\_

### Member Information

Payee's Name \_\_\_\_\_ SSN \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_ E-mail Address \_\_\_\_\_

### FEDERAL INCOME TAX

**(FOR COMPLETE INSTRUCTIONS, REFER TO IRS FORM W-4P OR CALL YOUR TAX PREPARER.)**

☐ **NO CHANGE Necessary (Only select if no other items marked for this option)**

1(a). ☐ Do not withhold any Federal Income Tax. **CAUTION:** There are penalties for not paying enough Federal Income Tax during the year either through withholding or estimated tax payments.

1(b). ☐ Withhold Federal Income Tax based on the following:

\_\_\_\_ For yourself

\_\_\_\_ For your spouse

\_\_\_\_ Number of children or other dependents

\_\_\_\_ Head of Household (enter one if you file Head of Household)

\_\_\_\_ Child tax credit

\_\_\_\_ **TOTAL EXEMPTIONS** (add lines above, enter zero for no exemptions)

Please check filing status: ☐ Single ☐ Married ☐ Married but withhold at higher single rate

☐ Withhold an additional \$ \_\_\_\_\_ per month for Federal Income Tax.

**\*This form will override all previous requests**

### STATE INCOME TAX

**(FOR COMPLETE INSTRUCTIONS, REFER TO STATE OF ARKANSAS FORM AR4P OR CALL YOUR TAX PREPARER.)**

☐ **NO CHANGE Necessary (Only select if no other items marked for this option)**

2(a). ☐ Do not withhold any Arkansas State Income Tax. **CAUTION:** There are penalties for not paying enough Arkansas State Income Tax during the year either through withholding or estimated tax payments.

2(b). ☐ Withhold Arkansas State Income Tax based on the following:

\_\_\_\_ Single and you claim yourself

\_\_\_\_ Married and you claim yourself and your spouse

\_\_\_\_ Head of Household

\_\_\_\_ Number of children or dependents

\_\_\_\_ **TOTAL EXEMPTIONS** (add lines above, enter zero for no exemptions)

Please check filing status: ☐ Single ☐ Married

☐ Withhold an additional \$ \_\_\_\_\_ per month for Arkansas State Income Tax.

**\*This form will override all previous requests**

Payee's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Direct Deposit Authorization Form

**Payee Type:** ☐ Member ☐ Survivor ☐ Beneficiary ☐ QDRO Recipient • Member's SSN: \_\_\_\_\_

Payee Information		
Payee's Name _____	SSN _____	
Mailing Address _____		
City _____	State _____	Zip _____
Telephone Number (____) _____		E-mail Address _____

I hereby authorize the Arkansas Teacher Retirement System (ATRS) to deposit to the account indicated below the net amount I am due each month as if a check had been delivered to me for that amount. Should an overpayment or underpayment be made, ATRS is authorized to initiate any debits or credits necessary to correct the account.

### Account Information

By providing my account information below in lieu of attaching a voided check I understand that ATRS shall have no liability or responsibility for loss due to erroneous information supplied by me or my duly authorized representative.

Account Type: ☐ Checking Account ☐ Savings Account

Financial Institution Name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Routing Number (ACH) \_\_\_\_\_

Account Number \_\_\_\_\_

I consent to the disclosure by the above listed financial institution to ATRS the identity of all joint account holders, and any information that ATRS requests to effectuate, administer, or enforce the authorized transactions.

This authority is to remain in full effect until ATRS has received written notification from me of its termination. I understand that by having my benefits deposited in this manner, I will receive a deduction statement in July and December and that there will be no charge for this service.

Payee's Signature \_\_\_\_\_ Date \_\_\_\_\_

If you are a power of attorney, conservator, or guardian over the payee, please include a copy of the power of attorney, or certified copy of the order. If you are a trustee, please include a copy of the trust agreement.