Kentucky Retirement Systems
Perimeter Park West •1260 Louisville Rd. • Frankfort KY 40601-6124
Phone: (502) 696-8800 • Fax: (502) 696-8822 • kyret.ky.gov

Revised 10/2013

Notification of Retirement Instructions

Ready to retire? Completing this form is your first step. Please call our office at 1-800-928-4646 if you have questions or if you need assistance completing forms. Members are encouraged to visit our website at kyret.ky.gov for additional information.

Form 6000 - Notification of Retirement

You should submit your Form 6000 at least one month prior to your effective retirement date. Please note that you cannot file your Form 6000 more than 6 months prior to termination of employment.

The Form 6000 contains several sections. Please review this form carefully and refer to the instructions for each section. Additional instructions for completing Section G - Tax Withholding are provided on page 3.

Required Documents: Please write your Member ID on each copy you send to us.

- Member's Birth Certificate
- Beneficiary's Birth Certificate - If you name a person as beneficiary of your retirement account, we need a copy of their birth certificate too.

Your Member ID

Your Member ID is a six-digit, unique account number for your KRS account. If you received this form from our office, your Member ID is provided. If you access this form from our website and don't know your Member ID, you can contact our office at 1-800-928-4646. You will need to provide your Social Security Number and your four-digit KRS PIN to obtain your Member ID.

Form 6200 - Insurance Application

If you will be receiving a monthly payment, you may be eligible for health insurance coverage for you, your spouse, and eligible dependents. KRS offers Medicare and non-Medicare plans. You may access insurance applications and enrollment booklets by visiting our website at kyret.ky.gov. Please call our office to request a printed copy.

You must return an insurance application by the deadlines described below, even if you wish to waive coverage. If you are not Medicare eligible and you fail to return a completed application, you will be enrolled automatically in the Standard Consumer Driven Health Plan option with single coverage. If you are Medicare eligible and you fail to return a completed application, you will be enrolled automatically in the KRS Health Plan Medical Only. If you choose not to participate in the coverage, you will need to complete the Form 6200 to waive your coverage; otherwise, you will be enrolled automatically into a default plan as described above.

Insurance Application Deadlines

For insurance coverage to begin the same month as your retirement payment, you must file a Form 6200 with our office by the last day of the month *prior* to the month you retire. For example:

Retirement Date	Application Due By	Insurance Effective Date
May 1	April 30	May 1

If you miss the above deadline, you can still submit an application. Your Form 6200 must be filed with our office within 30 days of the first day of the month in which you retire. For example:

Retirement Date	Application Due By	Insurance Effective Date
May 1	May 30	June 1

Additional instructions are provided on the following page. Keep reading to find out your deadline for returning retirement forms.

Your Next Step: Check your mailbox.

Once we process your Form 6000, we will send you additional forms for completion. The checklists below will help you decide which forms you need to return to our office.

If you elect to receive a monthly benefit, complete and return the following:

- ☐ Form 6010, Estimated Retirement Allowance
- ☐ Form 6200, Insurance Application *(refer to insurance application and deadlines on page 1)*
- ☐ Form 6025, Direct Rollover/Direct Payment Election*

**Form 6025 is only required if you select the Partial Lump Sum Option, which is only available for retirement dates of August 1, 2002 through January 1, 2009.*

If you elect to receive an actuarial or lump sum refund complete and return the following:**

- ☐ Form 6010, Estimated Retirement Allowance
- ☐ Form 6025, Direct Rollover/Direct Payment Election

***We require additional verification from your employer before we can process a refund which may delay your check. Upon receipt of the above forms, we will mail required forms to you and your employer for completion.*

All required forms and documentation must be filed with our office by the last day of the month prior to your effective retirement date. *You are responsible for filing your insurance application prior to the deadlines noted on page 1 or you will be enrolled automatically into a default plan.*

Retirement Date	Due Date
January 1	December 31
February 1	January 31
March 1	February 28
April 1	March 31
May 1	April 30
June 1	May 31
July 1	June 30
August 1	July 31
September 1	August 31
October 1	September 30
November 1	October 31
December 1	November 30

If you have any questions, please contact our office at (502) 696-8800 or (800) 928-4646.
Our office is open from 8:00 am to 4:30 pm Monday through Friday.

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Form W4-P Instructions

Your monthly retirement benefit is subject to federal taxes. **You may choose your federal tax withholding preference by completing Section G of your Form 6000, Notification of Retirement.** ***If you do not complete Section G, KRS will automatically withhold federal income tax based on married status with 3 exemptions.*** You may find the worksheets below helpful when completing Section G.

Additional information is available on the Internal Revenue Service website at www.irs.gov.

Purpose. Form W4-P 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 W4-P to tell payers the correct amount of federal income tax to withhold from your payment(s). You also may use Form W4-P to choose (a) not to have any federal 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. Your previously filed Form W-4P will remain in effect if you do not file a Form W-4P for 2015.

What do I need to do? Complete lines A through **G** of the **Personal Allowances Worksheet.** Use the additional worksheets on the following page 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 W4-P, Section G of the Form 6000.

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*. 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

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 $65,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $65,000 and $84,000 ($100,000 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 the next page.
- 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 $50,000 ($20,000 if married), see the **Multiple Pensions/More-Than-One-Income Worksheet** on the next page 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 (Section G of Form 6000).

SAMPLE

SAMPLE

Deductions and Adjustments Worksheet

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

1 Enter an estimate of your 2015 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1951) of your income, and miscellaneous deductions. For 2015, you may have to reduce your itemized deductions if your income is over $309,900 and you are married filing jointly or are a qualifying widow(er); $284,050 if you are head of household; $154,950 if you are single and not head of household or a qualifying widow(er); or $258,250 if you are married filing separately. See Pub. 505 for details . . . **1** $ ______

2 Enter: $12,600 if married filing jointly or qualifying widow(er) / $9,250 if head of household / $6,300 if single or married filing separately . . . **2** $ ______

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . **3** $ ______

4 Enter an estimate of your 2015 adjustments to income and any additional standard deduction (see Pub. 505) . . . **4** $ ______

5 **Add** lines 3 and 4 and enter the total. (Include any credit amounts from the *Converting Credits to Withholding Allowances for 2015 Form W-4* worksheet in Pub. 505.) . . . **5** $ ______

6 Enter an estimate of your 2015 income not subject to withholding (such as dividends or interest) . . . **6** $ ______

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . **7** $ ______

8 **Divide** the amount on line 7 by $4,000 and enter the result here. Drop any fraction . . . **8** ______

9 Enter the number from the **Personal Allowances Worksheet**, line G, page 1 . . . **9** ______

10 **Add** lines 8 and 9 and enter the total here. If you use the **Multiple Pensions/More-Than-One-Income Worksheet**, also enter this total on line 1 below. Otherwise, **stop** here and enter this total on Form W-4P, line 2, Section G of the Form 6000. . . . **10** ______

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).

1 Enter the number from line G, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**). . . . **1** ______

2 Find the number in **Table 1** below that applies to the **LOWEST** paying pension or job and enter it here. **However**, 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" . . . **2** ______

3 If line 1 is **more than or equal to** 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. **Do not** use the rest of this worksheet . . . **3** ______

Note. If line 1 is **less than** 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.

4 Enter the number from line 2 of this worksheet . . . **4** ______

5 Enter the number from line 1 of this worksheet . . . **5** ______

6 **Subtract** line 5 from line 4 . . . **6** ______

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying pension or job and enter it here **7** **$** ______

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . **8** **$** ______

9 **Divide** line 8 by the number of pay periods remaining in 2015. For example, divide by 12 if you are paid every month and you complete this form in December 2014. Enter the result here and on Form W-4P, line 3, Section G of the Form 6000. This is the additional amount to be withheld from each payment. . . **9** **$**

Table 1

Married Filing Jointly: If wages from **LOWEST** paying job or pension are—	Enter on line 2 above	All Others: If wages from **LOWEST** paying job or pension are—	Enter on line 2 above
$0 - $6,000	0	$0 - $8,000	0
6,001 - 13,000	1	8,001 - 17,000	1
13,001 - 24,000	2	17,001 - 26,000	2
24,001 - 26,000	3	26,001 - 34,000	3
26,001 - 34,000	4	34,001 - 44,000	4
34,001 - 44,000	5	44,001 - 75,000	5
44,001 - 50,000	6	75,001 - 85,000	6
50,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 -115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly: If wages from **HIGHEST** paying job or pension are—	Enter on line 7 above	All Others: If wages from **HIGHEST** paying job or pension are—	Enter on line 7 above
$0 - $75,000	$600	$0 - $38,000	$600
75,001 - 135,000	1,000	38,001 - 83,000	1,000
135,001 - 205,000	1,120	83,001 - 180,000	1,120
205,001 - 360,000	1,320	180,001 - 395,000	1,320
360,001 - 405,000	1,400	395,001 and over	1,580
405,001 and over	1,580		

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Form 6000
Revised 01/2013

Notification of Retirement

Please read the instructions for each section and complete all information requested in Sections A-G. Section H must be completed by your current employer. Section I must also be completed if applying for disability retirement.

Section A: Member Information

You must attach a copy of your birth certificate to this form.

Member Name:		Member ID:	
Address:	City:	State:	Zip Code:
Would you like to receive information via email? ☐ Yes ☐ No			
E-mail:		Phone:	
Date of Birth:	Maiden Name:	Sex: ☐ Male ☐ Female	

You must provide a termination date and retirement date below.

Termination Date: ____________ ______ ________
Month Day Year
(YOUR TERMINATION DATE MUST BE PRIOR TO YOUR RETIREMENT DATE.)

Retirement Date: ____________ 1, ________
Month Year
(YOUR RETIREMENT DATE MUST BE THE FIRST DAY OF THE MONTH.)

Section B - Type of Retirement

If applying for normal or early retirement, you may not submit this form more than 6 months prior to termination of employment. You must terminate your employment to be eligible for early or normal retirement benefits.

Disability Retirement applicants must complete Section I.

☐ **NORMAL OR EARLY RETIREMENT** ☐ **DISABILITY RETIREMENT**

Section C: Retirement Systems

Check the appropriate box or boxes to indicate the retirement systems in which you have an account.

☐ **Kentucky Employees Retirement System - KERS** (state employees, health departments, universities)
☐ **County Employees Retirement System - CERS** (city, county, local governments, classified employees of boards of education)
☐ **State Police Retirement System - SPRS** (full-time officers of Kentucky State Police)

Other State Administered Retirement Systems
If you have an account in one of the systems administered by Kentucky Retirement Systems (KERS, CERS, or SPRS) and in one of the other state administered retirement systems (listed below), you may need to complete the retirement application for the other system prior to your termination in order to be eligible for reciprocal benefits from all systems.

☐ **Kentucky Teachers' Retirement System - KTRS** (certified employees of boards of education)
☐ **Legislators' Retirement Plan - LRP** (State Senators and Representatives)
☐ **Judicial Retirement Plan - JRP** (Judges)

Section D - Retirement Account Beneficiary Designation

Your account beneficiary can only be one person, a trust or your estate. Indicate your beneficiary by checking one of the beneficiary types below and providing the necessary information. This designation will become invalid if you file a new Form 6000 prior to your effective retirement date or if this form is voided.

Member Name:	Member ID:

☐ **Person** Attach a copy of this person's birth certificate to this form with your Member ID written on it.

Name:		Social Security Number:	
Date of Birth:		◯ Male	◯ Female
Relationship:	☐ Check this box if this person is also your legal spouse.		
Address:	City:	State:	Zip Code:

☐ **My Estate** No additional information required.

☐ **Living Trust** The following information is required to designate a living trust. You must write the name of the trust as it appears in the trust document and submit a copy of the trust with this form. A charitable organization or a religious charity cannot be named as beneficiary unless it is a trust.

Name of Trust:			
Trust Tax ID:	Date of Trust:		
Trustee or Successor Trustee Contact Information: Our office will contact the trustee listed below following your death.			
Trustee:	Successor Trustee (if applicable):		
Address:	City:	State:	Zip Code:

☐ **Testamentary Trust** A testamentary trust is established by the member's will and takes effect following the member's death. No additional information required.

Section E - $5000 Death Benefit from Kentucky Retirement Systems - Complete only if eligible

To be eligible for this benefit, you must be a retired member receiving a monthly benefit on the date of your death from Kentucky Retirement Systems based on a minimum of 48 months of service.

If eligible for this benefit, you may name one death benefit beneficiary. This designation is not valid if you designate more than one beneficiary. Your estate will become your default beneficiary if this designation is deemed to be invalid. This designation may be changed at any time prior to your death by filing a properly completed Form 6030, Death Benefit Designation.

Member Name:	Member ID:

☐ **Person** You may only name one person as your death benefit beneficiary.

Name:		Social Security Number:	
Date of Birth:	Relationship:	◯Male ◯Female	
Address:	City:	State:	Zip Code:

☐ **My Estate** No additional information required.

☐ **Living Trust** The following information is required to designate a living trust. You must write the name of the trust as it appears in the trust document and submit a copy of the trust with this form. A charitable organization or a religious charity cannot be named as beneficiary unless it is a trust.

Name of Trust:			
Trust Tax ID:	Date of Trust:		
Trustee or Successor Trustee Contact Information: Our office will contact the trustee listed below following your death.			
Trustee:	Successor Trustee (if applicable):		
Address:	City:	State:	Zip Code:

☐ **Testamentary Trust** A testamentary trust is established by the member's will and takes effect following the member's death. No additional information required.

☐ **Funeral Home** Please enclose a copy of the Funeral Home License with your Member ID written on it.

Funeral Home Legal Name:		Funeral Home License Number:	
Funeral Home Tax ID:	Contact Name:	Phone:	
Address:	City:	State:	Zip Code:

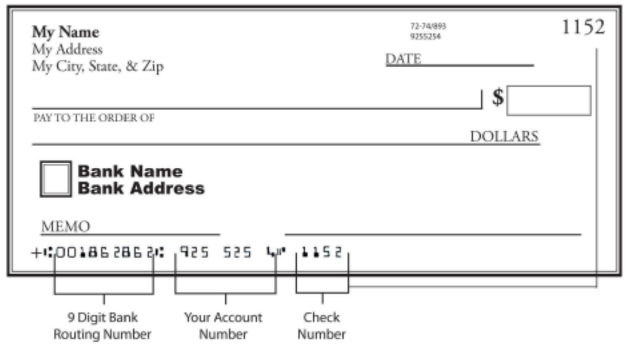
Section F - Authorization for Deposit of Retirement Payment

Complete this section to authorize deposit of your retirement benefit directly into your account at a financial institution.

Financial Institution Information: The financial institution may be a bank, savings bank, savings and loan association, credit union, or similar institution that is a member of the Automated Clearing House (ACH). Your direct deposit institution may be changed at any time by filing a properly completed Form 6130, Authorization for Deposit of Retirement Payment.

Financial Institution Name:	
Depositor Routing Number:	
Depositor Account Number:	
Account Type:	◯ Checking ◯ Savings

For your convenience:
The sample check shows where to locate the required bank information to complete your Direct Deposit.



Required Documents: Please indicate the documentation you are submitting with this form.

For deposits to a Checking Account: I have attached to this form	◯ a VOIDED personalized check ◯ verification from my financial institution
For deposits to a Savings Account: I have attached to this form	◯ verification from my financial institution

Attach Voided Check Here:

(Attach Voided Check Here)

YOU MUST READ AND CHOOSE ONE OF THE STATEMENTS BELOW REGARDING ELECTRONIC PAYMENTS

I acknowledge that electronic payments to the designated account must comply with the provisions of U.S. law, as well as the requirements of the Office of Foreign Assets Control (OFAC) and National Automated Clearing House Association (NACHA) regulations.

Check one of the following:

☐ I affirm that, regarding electronic payments that Kentucky Retirement Systems may remit to the financial institution for credit to the account that I have designated, the entire payment amount **is not** subject to being transferred to a foreign bank account.

☐ I affirm that, regarding electronic payments that Kentucky Retirement Systems may remit to the financial institution for credit to the account that I have designated, the entire payment amount **is** subject to being transferred to a foreign bank account. I understand that the remitting agency will remit future payments to me via paper check instead of electronically.

ONE of these boxes MUST BE SELECTED IN ORDER FOR THIS FORM TO BE VALID.

Section G - Tax Withholding

Your monthly retirement benefit is subject to federal taxes. You may choose your federal tax withholding preference below. If you do not complete this section, KRS will automatically withhold federal income tax based on married status with 3 exemptions. You may refer to the instructions for Form W4-P provided with your retirement application. You may change your tax withholding at any time by filing a properly completed Form 6017, W-4P, Tax Withholding.

Form **W-4P** Department of the Treasury Internal Revenue Service	**Withholding Certificate for Pension or Annuity Payments**	OMB No. 1545-0074 FOR TAX YEAR IN WHICH MEMBER RETIRES

Type or print your full name.			Member ID:
Address:			Claim or identification number (if any) of your pension or annuity contract
City:	State:	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 lines 2 or 3.) ☐

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

Marital status: ☐ Single ☐ Married ☐ Married, but withhold at higher "Single" rate

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.)* .... $ _________

Notification of Retirement Certification

I certify the information in this Notification of Retirement is correct and that my employer has been informed of my intent to terminate employment on the date indicated on this form if applying for early/normal retirement. I understand Kentucky Retirement Systems will send an estimated retirement allowance. **I acknowledge my estimated retirement allowance and benefits are subject to post retirement audit and adjustment after retirement.**

Signature of Member: ________________________________ Date: ____________________

Signature of Witness: ________________________________ Date: ____________________

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Section H - Employer Certification of Leave Balances and Final Salary

Section H must be completed by your current employer and returned to Kentucky Retirement Systems in order to include future salary, service and sick and compensatory leave balances in your estimated retirement allowance. If you are currently employed by more than one participating employer, each employer should complete a copy of Section H of this form. If you do not have the employer complete Section H of this form, Kentucky Retirement Systems will **exclude** all leave balances from the estimated retirement allowance. **Your estimated retirement allowance and benefits are subject to post retirement audit and adjustment after retirement.**

Note to Employer: KRS will provide calculations to the member based upon the information you certify below. You should list any salary yet to be reported through the member's anticipated termination date. State funded expenses for elected officials should not be certified on this form. If the member has an active Installment Purchase of Service Agreement (IPS), you do not need to certify the IPS payments that are scheduled through the member's termination date.

Employer Name:	Employer Code:
Member Name:	Member ID:
Termination Date:	
Employer's Report of Leave Balances as of:	Compensatory Leave Balance:

Does your agency participate in a sick leave program administered by KRS? ◯ Yes ◯ No

If yes above, select the type of sick leave plan: ◯ Standard ◯ Alternate

Does the above member work an average of 21 days per month? ◯ Yes ◯ No

If no above, please provide an Alternate Average Working Days Per Month: ______________________

Standard Sick Leave Program: If participating in the standard sick leave program, please provide the following information. Note: Contributions should not be withheld from standard sick leave lump sum payouts.

Accumulated Sick Leave (in hours):	Hours in a Sick Leave Day:

Alternate Sick Leave Program: If participating in the alternate sick leave program, please provide the following information. Note: Contributions should be withheld from alternate sick leave lump sum payouts.

Accumulated Sick Leave (in days):	Hours in a Sick Leave Day:
Estimated Compensation to be Paid for Sick Leave:	

School Board Certification *(school board employees only)*: Indicate the number of actual days the member will have worked through the expected termination date. If the days occur in different school years, please list each school year separately below.

Actual Days Worked through Expected Termination Date	
School Year	Number of Actual Days

Section H is continued on the following page. You must complete the Employer Certification at the end of Section H.

Section H *Continued* - Employer Certification of Leave Balances and Final Salary

Employer Name:	Employer Code:
Member Name:	Member ID:
Termination Date:	

Is there additional salary to be reported through the member's anticipated termination date: ◯ Yes ◯ No
If YES, please complete the following section.

Employer's Report of Final Salary

You may select from the following payment reasons: Regular Pay, Regular Pay with Additional Creditable Compensation, Lump Sum Compensatory Pay, or Bonus/Severance Payment.

Posting Month	Payment Reason	Salary

Employer Certification

I certify that the leave balances and estimated final salary information provided above is accurate based upon our agency's records. I state that I have full knowledge of the penalty in KRS 523.100 related to falsification of records and that the information provided is true and accurate.

Printed Name of Agency Official: ____________________

Title: ____________________ Agency Phone Number: ____________________

Signature of Agency Official: ____________________ Date: ____________________

Section I - Member's Statement of Disability

If additional space is required to answer the questions, you may use and attach additional paper.

Member Name:	Member ID:

1. List the diagnoses of the injury, illness, or disease for which you are applying for disability:

2. Describe how the diagnoses listed above on this page prevent you from performing your essential job duties:

3. Describe the history of the diagnoses listed above, including the onset or start of your symptoms or complaints:

4a. If you are a non-hazardous employee, are you claiming that you are totally and permanently disabled from performing any occupation for remuneration or profit as a result of a single traumatic event that occurred while you were performing the duties of your job or a single act of violence committed against you that was related to your job duties?

☐ Yes ☐ No

Please note: A duty related injury does not include the effects of the natural aging process, a communicable disease unless the risk of contracting the disease is increased by the nature of the employment, or a psychological, psychiatric, or stress related change unless the direct result of a physical injury.

4b. If you are a hazardous employee, are you claiming that you are disabled as a result of an act in the line of duty?

☐ Yes, this is the direct result of an injury sustained while performing the principal duties of the hazardous position.

☐ No

If you answered yes to 4a or 4b, describe specific date, time, and circumstances of the duty related injury or act in line of duty below. Please attach a copy of the employer incident report to this form. Failure to attach the employer incident report will delay your disability application.

Section I is continued on the following page. You must complete the Certification at the end of Section I.

Section I *Continued* - Member's Statement of Disability

Member Name:	Member ID:

Last Day of Paid Employment

Last Day of Paid Employment: The last day of paid employment is the last day for which contributions were reported and for which you were eligible to receive retirement credit. Identify the month, day, and year that is your last day of paid employment, or if you are still working or on paid leave, identify the month, day, and year that is your anticipated last day of paid employment.

Last Day of Paid Employment: ____________ Month ______ Day ______ Year

You will be sent an estimate of disability retirement benefits, subject to post retirement audit and adjustment after retirement, based upon your last day of paid employment in a regular full-time position assuming your application for disability retirement benefits is approved. If approved for disability benefits, you will receive benefits effective the first day of the month following your last day of paid employment.

Certification and Authorization

I certify the information on this Statement of Disability, Section I, is true and correct. I acknowledge that any person who makes a false statement, report, or representation is subject to penalty pursuant to KRS 523.010 to 523.110.

I authorize the Board of Trustees, its agents, servants, and employees to have full and complete access to any and all medical records of mine, whether or not related to this injury, illness, or disease, and authorize the Board of Trustees, and its agents, servants, and employees to discuss such records as it may be necessary at any meeting of the Board in connection with my application for disability retirement benefits.

I authorize my employer to release, furnish, disclose, or discuss with the Kentucky Retirement Systems all records or other information regarding my employment, including but not limited to, a description of job duties performed as of the last day of my employment, a description of the accommodations, assistance, or help that was offered or attempted or reasonably available to allow me to perform my essential job duties, a report of work injuries or accidents, my personnel file, or other employee records.

Signature of Member: ______________________________ Date: ____________________

Signature of Witness: ______________________________ Date: ____________________