Disability Benefits Application Change Request form – Information and Instructions

GENERAL INFORMATION:

Use this form to change elections made on the *Disability Benefits Application* or the *DR Option Quote form (DS1354)*. When completing this form, be sure to carefully read the instructions. Failure to complete this form in its entirety or failure to provide the necessary or required information may result in a delay or denial of your change request. This form may not be used to make changes to service retirement benefits.

Important: If you have been approved for disability benefits and want to change your Defined Benefit election, CalSTRS must receive your Change Request form no later than 30 days after your first disability benefit payment has been issued by CalSTRS.

You must complete Section 1 and 5.

For Section 2 through 4.2, only complete the sections that apply to the changes you wish to make.

Refer to your previously submitted *Disability Benefits Application* when completing this form. See *Your Disability Benefits Guide* for more information.

SECTION 1: MEMBER INFORMATION

Include your home telephone number, alternate telephone number and your email address so we can contact you if we have questions. Be sure your name on the Change Request form matches your name as it appears on your Social Security card. For security purposes, include your Client ID instead of your Social Security number. Indicate your coverage: A or B.

Your Client ID and type of coverage are on your *Retirement Progress Report.*

SECTION 2: DEFINED BENEFIT - BENEFIT EFFECTIVE DATE CHANGE OR BENEFIT CANCELLATION

Please note that your benefit effective date cannot be earlier than the first day of the month of which your disability application was received or the day following the last day of compensation as reported by your employer, whichever is later.

Check the appropriate box to:

□ Change your disability benefit effective date.

□ Cancel your previously submitted *Disability Benefit Application*. This will terminate your disability benefit and restore your account to active member status.

□ Cancel your previously submitted *Disability Benefits Application*, and remain on Service Retirement.

SECTION 3: DEFINED BENEFIT ELECTION CHANGE OR ELECTION CANCELLATION

The deadline to change or cancel your Defined Benefit Member-Only or Modified Benefit election is 30 days from the date your first benefit payment is issued by CalSTRS. The change or cancellation will be effective on your disability benefit effective date.

Check the appropriate box to:

□ Cancel your Modified Benefit and elect a Member-Only Benefit

□ Cancel your Member-Only Benefit and elect a Modified Benefit with an option.

□ Change your previous option election to a new option election (100%, 75%, 50%, Compound)

□ Change your option beneficiary.

If you are naming a new option beneficiary, include birth date and Social Security number verification. Acceptable documents for birth date verification include a photocopy of a birth certificate, passport ID page and certain military IDs.

SECTION 4: DEFINED BENEFIT SUPPLEMENT ELECTION CHANGE

Check the box to:

□ Change your Defined Benefit Supplement election.

Choose your new Defined Benefit Supplement election. Be sure your new Defined Benefit Supplement election is permitted with your Defined Benefit election. If your Defined Benefit Supplement account balance is less than $3,500, you are only eligible to receive a lump-sum

payment. If your Defined Benefit Supplement account is greater than $3,500, you have three payment choices.

SECTION 4.1: DEFINED BENEFIT SUPPLEMENT PAYMENT INSTRUCTIONS

Check the appropriate box to:

□ Choose a direct payment for your Defined Benefit Supplement distribution.

□ Choose a roll-over for all or part of your Defined Benefit Supplement distribution.

Rollover of Tax-Deferred Contributions and Interest

The amount of tax-deferred contributions and interest in your Defined Benefit Supplement account is shown on your *Retirement Progress Report*. Your account balance must be $200 or more to qualify for a rollover to a financial institution. Enter the dollar amount or the percentage (from 1% to 100%) that you would like to rollover.

Financial Institution Information

When providing your financial institution information, do not attach transfer documents. Also, do not list "IRA" as the name of your financial institution. We will mail the payment to the financial institution address you provide. It is imperative the financial institution name, address and account number are correct. You must also provide the financial institution representative's signature. If the information is not correct, your rollover will be delayed. We are not able to process direct rollovers to financial institutions outside the U.S.

CalSTRS Pension2® Rollovers–You may select CalSTRS Pension2 for your rollover of contributions and interest without obtaining the financial institution representative's signature. CalSTRS will obtain the required signatures on your behalf.

For more information, visit Pension2.com. You may also email at Pension2@CalSTRS.com or call 888-394-2060, Monday–Friday, 8 a.m. to 5 p.m.

IMPORTANT: If you are doing a rollover, be sure to read Section 11 (*Special Tax Notice: Your Rollover Options)* of your *Disability Benefits Application*.

SECTION 4.2: DEFINED BENEFIT SUPPLEMENT TAX WITHHOLDING PREFERENCES

Direct Payment Lump Sum or Period-Certain Annuity of 3 to 9 Years

Complete this section if you chose a lump sum or period - certain annuity of 3 to 9 years for your Defined Benefit Supplement funds. If you choose to have payments paid directly to you, CalSTRS must withhold 20 percent for federal tax. You may choose to have California state tax withheld.

Lifetime Monthly Annuity or Period-Certain Annuity of 10 Years

Complete this section if you elected a lifetime annuity or a period-certain annuity of 10 years for your Defined Benefit Supplement funds.

If you do not complete this section, CalSTRS will withhold federal and state income tax from your monthly payments based on the rate for a married individual claiming three withholding allowances. If you do not want taxes withheld, return the form with the Do Not Withhold boxes checked. If you want taxes withheld, mark the appropriate boxes and specify the number of allowances. You may specify an additional dollar amount to withhold. You may also elect to withhold a flat dollar amount without specifying allowances for California state tax.

SECTION 5: REQUIRED SIGNATURES

Check all boxes that apply, then sign and date your *Disability Benefits Application Change Request* form. If you are married or registered as a domestic partner, your spouse or partner also must sign and date your application. Your signature date is the date you signed your application. If your spouse or registered domestic partner does not sign your application, you must include a completed and signed J*ustification for Non-Signature of Spouse or Registered Domestic Partner* form with your application. This form may require supporting documentation.

If you divorced or terminated a registered domestic partnership and a portion of your CalSTRS benefits was awarded to a former spouse or partner, check the box that indicates this. You may need to refer to your settlement agreement to make this determination. In

addition, if your court documents have not been reviewed by CalSTRS, you may be asked to provide them later.

SUBMITTING YOUR DISABILITY BENEFITS APPLICATION CHANGE REQUEST

Submit pages 1 –7of your *Disability Benefits Application Change Request* form by one of the methods below. Keep a copy of your completed form for your records. If you fax this form, keep a copy of the confirmation page. We are unable to call and confirm receipt of your faxed forms.

Hand Delivery

Hand deliver your form to a local CalSTRS benefits planning office. For a current listing, visit CalSTRS.com.

Mail Your Application

CalSTRS
P.O. Box 15275, MS 43
Sacramento, CA 95851-0275

Overnight Delivery

If you are using a special mailing service such as UPS or FedEx, send your form to:

CalSTRS
Member Services
100 Waterfront Place
West Sacramento, CA 95605

Fax Delivery

916-414-5784

QUESTIONS?

Email questions using your *my*CalSTRS account or at CalSTRS.com/contact, or call 800-228-545

Disability Benefits Application Change Request Form

DS1328 New 07/17

California State Teachers' Retirement System

P.O. Box 15275, MS 43
Sacramento, CA 95851-0275
800-228-5453
CalSTRS.com

Use this form to change any elections made/confirmed on the *Disability Benefits Application* (DS260) or the *DR Option Quote* form (DS1354). For a defined benefit election change or cancellation, CalSTRS must receive this change request form no later than 30 days after your first disability benefit payment has been issued by CalSTRS.

Section 1: Member Information

NAME (LAST, FIRST, INITIAL)			CLIENT ID OR SOCIAL SECURITY NUMBER
MAILING ADDRESS			DATE OF BIRTH (MM/DD/YYYY)
CITY	STATE	ZIP CODE	HOME TELEPHONE ( )
EMAIL ADDRESS			ALTERNATE PHONE NUMBER
COVERAGE TYPE (CIRCLE ONE):	A	B	

Section 2: Disability Benefit: Benefit Effective Date Change or Disability Benefit Application Cancellation

Check the appropriate box. I previously submitted my *Disability Benefits Application* and I now request to:

- ☐ Change my disability benefit effective date from _____/_____/_____ to _____/_____/_____.
- ☐ Cancel my previously submitted *Disability Benefits Application* only.
- ☐ Cancel my previously submitted *Disability Benefits Application*, and remain on Service Retirement

Section 3: Defined Benefit Election Change or Cancellation

- ☐ **Cancel** my Modified Benefit; **I am now electing a Member-Only Benefit.**
- ☐ **Cancel** my Member-Only Benefit; **I am now electing a Modified Benefit** with an option.

Choose one of the following options and *complete the beneficiary information on the next page*:

- ☐ 100% Beneficiary Option
- ☐ 75% Beneficiary Option
- ☐ 50% Beneficiary Option
- ☐ Compound Option (If you choose the Compound Option, you must also complete and attach the *Compound Option Election* form.)

Section 3: Defined Benefit Election Change or Cancellation, continued

☐ **Change** my option from _____ to the following option (choose one):
(Previous option election)

- ☐ 100% Beneficiary Option
- ☐ 75% Beneficiary Option
- ☐ 50% Beneficiary Option
- ☐ Compound Option (If you choose the Compound Option, you must also complete and attach the *Compound Option Election* form.)

☐ **Change** my option beneficiary.

- For 100% Beneficiary Option, 75% Beneficiary Option, or 50% Beneficiary Option, complete the information below.
- To change a Compound Option beneficiary, skip this section and complete the remainder of this form. You must also complete and attach the *Compound Option Election* form.

☐ I am electing a special needs trust as my option beneficiary. (Do not enter beneficiary information below. If you choose to elect a special needs trust as your option beneficiary, you must also complete and attach the *Certification of a Special Needs Trust* form.)

THE NEW BENEFICIARY I AM ELECTING IS:

BENEFICIARY'S NAME (LAST, FIRST, INITIAL)		BENEFICIARY'S SOCIAL SECURITY NUMBER OR TAX ID
	( )	( )
MAILING ADDRESS	HOME TELEPHONE	ALTERNATE TELEPHONE NUMBER
CITY / STATE	ZIP CODE	DATE OF BIRTH (MM/DD/YYYY)

CALSTRS MEMBER?	RELATIONSHIP	GENDER	BIRTH DATE VERIFICATION ENCLOSED?
☐ YES ☐ NO	☐ SPOUSE ☐ REGISTERED DOMESTIC PARTNER (RDP) ☐ OTHER	☐ MALE ☐ FEMALE	☐ YES ☐ NO

Section 4: Defined Benefit Supplement Election Change

☐ **Change** my Defined Benefit Supplement election from my current choice, as elected on my *Disability Benefits Application* to my new election below (Complete the applicable portions of Section 4):

New Defined Benefit Supplement Election
You have three payment choices for your Defined Benefit Supplement account. Choose only one:

1. ☐ Lump-Sum Payment
- Check paid to me directly. (Skip to section 4.1, Direct Payment.)
- Rollover to a financial institution. (Skip to section 4.1, Rollover.)

Section 4: Defined Benefit Supplement Election Change, continued

2. ☐ **Annuity Payment**
You have two choices. Choose one:

☐ **Period-Certain Monthly Annuity of 3 to 10 years***
Number of years (circle one) 3 4 5 6 7 8 9 10

OR

☐ **Lifetime Monthly Annuity***
If you elected a **Member-Only Benefit**, you have one choice:
☐ Member-Only Annuity

If you elected a **Modified Benefit**, you have three choices (**Coverage B Only**). Choose one:
☐ 100% Beneficiary Annuity ☐ 75% Beneficiary Annuity ☐ 50% Beneficiary Annuity

3. ☐ **Combination Lump Sum *and* Annuity.**
After your lump-sum payment, at least $3,500 must remain in your Defined Benefit Supplement account to fund an annuity. Indicate your lump-sum amount ***and*** choose one annuity.

$_____Lump-Sum Amount
• Check paid to me directly. (Skip to section 4.1, Direct Payment.)
• Rollover to a financial institution. (Skip to section 4.1, Rollover.)

Annuity (choose one):

☐ **Period-Certain Monthly Annuity of 3 to 10 Years***
Number of years (circle one) 3 4 5 6 7 8 9 10

OR

☐ **Lifetime Monthly Annuity***
If you elected a **Member-Only Benefit,** you have one choice:
☐ Member-Only Annuity

If you elected a **Modified Benefit,** you have three choices (**Coverage B Only**). Choose one:
☐ 100% Beneficiary Annuity ☐ 75% Beneficiary Annuity ☐ 50% Beneficiary Annuity

**The lifetime annuity and period-certain annuities of 10 years are not eligible for a rollover into a pretax account.*

Section 4.1: Defined Benefit Supplement Payment Instructions

Indicate below if you want to receive your Defined Benefit Supplement distribution as a **direct payment** or a **rollover**.

Direct Payment

☐ I choose to have my Defined Benefit Supplement distribution paid directly to me. (Skip to section 4.2, Taxes.)

OR (see next page)

Section 4.1: Defined Benefit Supplement Payment Instructions, continued

Rollover

☐ I choose to roll over all or part of my Defined Benefit Supplement distribution to a financial institution. Any amount not designated for transfer will be mailed directly to me. (Complete the information on this page. If you choose a rollover to CalSTRS Pension2®, CalSTRS staff will obtain the financial institution representative's signature on your behalf.)

This Section Requires Your Financial Institution's Signature (Except for Pension2 Rollovers)

Rollover of Tax-Deferred Contributions and Interest. I elect to roll over my tax-deferred contributions and interest to one of the plans listed below.

☐ Traditional IRA ☐ Other eligible plan (403(b), 457, 401(k) or 401(a)) ☐ Roth IRA (taxable rollover)

Select one: ☐ Amount to transfer $_____ (enter flat amount)

OR

☐ Percentage to transfer _____ (indicate 1%–100%)

Financial Institution Information (All information is required)

ACCOUNT NUMBER	MAKE CHECK PAYABLE TO (FULL NAME OF FINANCIAL INSTITUTION)		
PAYMENT MAILING ADDRESS (FINANCIAL INSTITUTION)	CITY	STATE	ZIP CODE
NAME OF FINANCIAL INSTITUTION REPRESENTATIVE (PRINT)		( ) TELEPHONE NUMBER	EXTENSION
FINACIAL INSTITUITION REPRESENTATIVE SIGNATURE*		SIGNATURE DATE (MM/DD/YYYY)	

Rollover of After-Tax Contributions. I elect to roll over my after-tax contributions to one of the plans listed below (not applicable for most accounts).

☐ Traditional IRA ☐ Other eligible plan (403(b), 457, 401(k) or 401(a)) ☐ Roth IRA

Select one: ☐ Amount to transfer $_____ (enter flat amount)

OR

☐ Percentage to transfer _____ (indicate 1%–100%)

Financial Institution Information (All information is required)

ACCOUNT NUMBER	MAKE CHECK PAYABLE TO (FULL NAME OF FINANCIAL INSTITUTION)		
PAYMENT MAILING ADDRESS (FINANCIAL INSTITUTION)	CITY	STATE	ZIP CODE
NAME OF FINANCIAL INSTITUTION REPRESENTATIVE (PRINT)		( ) TELEPHONE NUMBER	EXTENSION

Section 4.1: Defined Benefit Supplement Payment Instructions, continued

FINACIAL INSTITUITION REPRESENTATIVE SIGNATURE*

SIGNATURE DATE (MM/DD/YYYY)

***Certification:** My signature above confirms the account number for the individual named at the top page 4. As a representative of the financial institution or plan named above, I certify that this institution or plan agrees to accept the funds described above as a direct trustee-to-trustee transfer from CalSTRS for deposit into a qualified IRA or other eligible plan as defined in the Internal Revenue Code. I understand that my signature above authorizes the transfer of funds as indicated above.*

Section 4.2: Defined Benefit Supplement Tax Withholding Preferences

Direct Payment Lump Sum and Period-Certain Annuities of 3 to 9 Years

Federal law requires that CalSTRS withhold 20 percent federal income tax for all lump-sum payments and period-certain annuities of 3 to 9 years paid directly to you. CalSTRS will automatically withhold federal tax from your payment.

Under state law, you can choose not to have any state tax withholding. If you choose to have state tax withholding, CalSTRS will withhold at 2 percent for lump-sum payments and period-certain annuities of 3 to 9 years paid directly to you.

Withhold California state income tax? ☐ Yes ☐ No

Section 4.2: Defined Benefit Supplement Tax Withholding Preferences continued

Lifetime Monthly Annuity or Period-Certain Annuity of 10 Years

If you do not complete this section, CalSTRS must withhold state and federal income tax from your payments based on rates for a married person claiming three withholding allowances.

CALIFORNIA STATE INCOME TAX WITHHOLDING

☐ **Do not** withhold California state income tax.

OR

☐ **Withhold** California state income tax.

☐ **Withhold** only $ _____ from each benefit payment.* (Enter a flat dollar amount only. Do not enter a percentage.)

OR

Withhold California state income tax based on the tax tables for (choose one):

☐ Married with _____
(Enter 0 or number of allowances.)

☐ Single with _____
(Enter 0 or number of allowances.)

☐ Head of household with _____
(Enter 0 or number of allowances.)

Additional withholding: $ _____
from each benefit payment in addition to the amount to be withheld based on state tax tables. (You cannot enter an amount without selecting one of the above options. Enter a dollar amount only.)

FEDERAL INCOME TAX WITHHOLDING

☐ **Do not** withhold federal income tax from my monthly benefit payment.

OR

☐ **Withhold** federal income tax based on the tax tables for (choose one):

☐ Married with _____
(Enter 0 or number of allowances.)

☐ Single with _____
(Enter 0 or number of allowances.)

Additional withholding: $ _____
from each benefit payment in addition to the amount to be withheld based on federal tax tables. (You cannot enter an amount without selecting one of the above options. Enter a dollar amount only.)

**A flat amount cannot be specified for federal income tax.*

Section 5: Required Signatures

Check all that apply - your current and previous marital status.

- ☐ I am married or registered as a domestic partner and both our signatures are below.
- ☐ I am married or registered as a domestic partner and my spouse or registered domestic partner did not sign below. I have completed and attached the *Justification for Non-Signature of Spouse or Registered Domestic Partner* form.
- ☐ I have never been married or in a registered domestic partnership, or I am widowed or my registered domestic partner has died.
- ☐ I have been divorced or have terminated a registered domestic partnership and my former spouse or partner *was awarded* a portion of my CalSTRS benefits.
- ☐ I have been divorced or have terminated a registered domestic partnership and my former spouse or partner *was not awarded* a portion of my CalSTRS benefits.

Signatures

I certify that I have read the *Disability Benefits Application Change Request Instructions* and the booklet, *Your Disability Benefits Guide*. I understand that any elections and/or designations made on this form supersede any previous elections and/or designations made.

I certify under penalty of perjury under the laws of the State of California that the foregoing information provided herein is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statements for the purpose of altering a benefit administered by CalSTRS and it m ay result in penalties, including restitution, up to one year in jail and a fine of up to $5,000 (Education Code section 22010).

MEMBER'S SIGNATURE	SIGNATURE DATE (MM/DD/YYYY)
SPOUSE'S OR REGISTED DOMESTIC PARTNER'S SIGNATURE	SIGNATURE DATE (MM/DD/YYYY)
SPOUSE'S OR PARTNER'S PRINTED NAME (LAST, FIRST, INITIAL)	SIGNATURE DATE (MM/DD/YYYY)