FORM #1: APPLICATION FOR RETIREMENT

CITY OF ATLANTA PENSION CENTER
2472 Jett Ferry Rd, Ste 400-410
Atlanta, GA 30338
Phone: (888) 594-0216
Fax: (866) 201-5033

Pension Plan:
- ○ Board of Education
- ○ Fire
- ○ General Employees
- ○ Police

Expected Benefit:
- ○ Normal Retirement
- ○ Early Retirement
- ○ Vested Retirement
- ○ Disability (in the line of duty)
- ○ Disability (not in the line of duty)

PARTICIPANT INFORMATION

Full Name: _____ Date of Birth: _____

SSN: _____ Hire Date: _____

Street Address: _____ Department: _____

City, State Zip: _____ Last Day of Work: _____

Phone Number: _____ Retirement Date*: _____

Email Address: _____

*No earlier than the day after your last day of work

SPOUSE/REGISTERED DOMESTIC PARTNER (DP) INFORMATION

Are you married or in a registered domestic partnership? Yes ○ No ●

If yes, provide the following: Spouse/DP's Full Name: _____

Spouse/DP's SSN: _____

Spouse/DP's DOB: _____

CONTINUITY OF SERVICE

Do you plan to: ○ take a vacation to run out your accrued vacation time, or ○ take a lump-sum payout

Has service been continuous? Yes ○ No ○ If no, explain: _____

Are you currently paying 'back pension' in order to buy back service? Yes ○ No ○

Have you ever had a break in employment due to military service? Yes ○ No ○

If yes, did you buy back any service within 2 years of returning to work? Yes ○ No ○

I hereby certify that the above facts are true and correct. Affirmed and subscribed before me this

_____ day of _____, _____.

_____
Notary's Signature

_____
Applicant's Signature

Notary stamp or seal:

FORM #2A: BENEFICIARY DESIGNATION FORM

CITY OF ATLANTA PENSION CENTER
2472 Jett Ferry Rd, Ste 400-410
Atlanta, GA 30338
Phone: (888) 594-0216
Fax: (866) 201-5033

Pension Plan:
- ◯ Board of Education
- ◯ Fire
- ◯ General Employees
- ◯ Police

Please indicate why you are completing this form:
- ◯ I am a new hire
- ◯ I am retiring
- ◯ I have had a change in spouse, registered domestic partner, or child

Employee's Name: _____ SSN: _____

Street Address: _____ Date of Birth: _____

City, State Zip: _____ Phone: _____

Are you married or in a registered domestic partnership (DP)? Yes ◯ No ◯

If yes, provide the following:

Spouse/DP's Name: _____

Spouse/DP's SSN: _____

Spouse/DP's Date of Birth: _____

Do you have children (of any age)? Yes ◯ No ◯

If Yes, list them below: (attach sheet if necessary)

Child's Full Name: _____ Child's Full Name: _____

Child's SSN: _____ Child's SSN: _____

Child's Date of Birth: _____ Child's Date of Birth: _____

Child's Full Name: _____ Child's Full Name: _____

Child's SSN: _____ Child's SSN: _____

Child's Date of Birth: _____ Child's Date of Birth: _____

Please provide a Designated Beneficiary that is not your spouse or your child:

Designated Beneficiary's Name: _____

Designated Beneficiary's SSN: _____

Designated Beneficiary's Date of Birth: _____

YOU MUST CHOOSE ONE OF THE FOLLOWING OPTIONS:*

*If you are Board of Ed (OR if you are General/Fire/Police hired before 9/1/2011), this designation applies to the monthly benefit due to spouse/minor children upon your death (or your refund if no monthly benefit is due). If you are General/Fire/Police hired after 9/1/2011, this designation only applies to your refund of contributions.

◯ Upon my death, please distribute my pension benefits to my spouse (or registered DP). If I am not married or my spouse (or registered DP) is deceased, please distribute in equal shares to my children. If I have no spouse (or registered DP) or children at death, distribute to my Designated Beneficiary.
(Please note that only minor children will be eligible for monthly benefits).

◯ Upon my death, please distribute my pension benefits a different way.
(If you choose this option, YOU MUST request and complete the Supplemental Beneficiary Designation Form.)

Employee's Signature:_____ Date:_____

FORM #3: DIRECT DEPOSIT AUTHORIZATION

CITY OF ATLANTA PENSION CENTER
2472 Jett Ferry Rd, Ste 400-410
Atlanta, GA 30338
Phone: (888) 594-0216
Fax: (866) 201-5033

This form must be returned with a voided check or documentation provided by your bank that includes your routing and account number. We CANNOT process this form without one of these documents.

Pension Plan:
- ○ Board of Education
- ○ Fire
- ○ General Employees
- ○ Police

Supporting Documentation:
- ○ Voided Check
- ○ Other Bank Documentation

PARTICIPANT INFORMATION

Full Name: _____

SSN: _____

Street Address: _____

City, State Zip: _____

Phone Number: _____

Email Address: _____

Bank Name:
- ☐ Atlanta Credit Union
- ☐ Other: _____

Account Type: ☐ Checking ☐ Savings

Routing #: _____ (9 digits)

Account #: _____

☐ Please update my address as indicated above

ALTERNATE ACCOUNT

Amount to be deposited in alternate account: _____

Bank Name:
- ☐ Atlanta Credit Union
- ☐ Other: _____

Account Type: ☐ Checking ☐ Savings

Routing #: _____ (9 digits)

Account #: _____

Whereby I authorize the Pension Fund Administrator to deposit my net pay to my account(s) at the above-named bank(s) or financial institution(s). I also authorize the Pension Fund Administrator to adjust any over/under deposit made to my account(s). I will not hold my bank(s) or financial institution(s) liable for any erroneous deposit or subsequent payroll adjustment by the Pension Fund Administrator, and I agree that the bank(s) or financial institution(s) listed above may treat each such deposit as if it were deposited by me in person.

_____ _____

Signature Date

FORM #4:
TAX FORM

CITY OF ATLANTA PENSION CENTER
2472 Jett Ferry Rd, Ste 400-410
Atlanta, GA 30338
Phone: (888) 594-0216
Fax: (866) 201-5033

PARTICIPANT INFORMATION

Pension Plan:
- ○ Board of Education
- ○ Fire
- ○ General Employees
- ○ Police

Full Name: _____

SSN: _____

Street Address: _____

City, State Zip: _____

Phone Number: _____

Email Address: _____

FEDERAL WITHHOLDING

1	☐ Check here **if you do not want any federal income tax withheld** from your pension or annuity. (NOTE: If you check this box, do not complete lines 2 or 3.)		
2	☐ Check here **if you want federal tax withheld** from each pension or annuity payment based on the number of allowances and marital status listed here. (NOTE: You may also designate an additional dollar amount on line 3.) For help determining your allowances, complete the Personal Allowances Worksheet found on page 4 of IRS Form W-4P.	Marital status: ○ Single ○ Married ○ Married, but withhold at higher single rate	_____ (# of allowances)
3	☐ Check here **if you want an additional amount withheld** from each pension or annuity payment. (Note: Enter an amount here only if you completed line 2.)		$_____

STATE WITHHOLDING

0	Please indicate your state of residence.		_____
1	☐ Check here **if you do not want any state income tax withheld** from your pension or annuity. (NOTE: If you check this box, do not complete lines 2 or 3.)		
2	☐ Check here **if you want state tax withheld** from each pension or annuity payment based on the number of allowances and marital status listed here. (NOTE: You may also designate an additional dollar amount on line 3.) For help determining your allowances, complete the Personal Allowances Worksheet found on the Withholding Certificate for Pension or Annuity Payments for the state in which you reside.	Marital status: ○ Single ○ Married ○ Head of Household	_____ (# of allowances)
3	☐ Check here **if you want an additional amount withheld** from each pension or annuity payment. (Note: Enter an amount here only if you completed line 2.)		$_____

Signature _____ Date _____

FORM #5A:
DISABILITY APPLICATION
EMPLOYEE STATEMENT

CITY OF ATLANTA PENSION CENTER
2472 Jett Ferry Rd, Ste 400-410
Atlanta, GA 30338
Phone: (888) 594-0216
Fax: (866) 201-5033

Pension Plan:
- ◯ Board of Education
- ◯ Fire
- ◯ General Employees
- ◯ Police

Disability Type:
- ◯ Not in line of duty
- ◯ In line of duty
- ◯ Catastrophic in line

Date: _____

PARTICIPANT INFORMATION

Full Name: _____ Date of Birth: _____

SSN: _____ Phone Number: _____

Street Address: _____ Department: _____

City, State Zip: _____ Job Title: _____

Physician's Name: _____ Date of Disability: _____
(Physician who first treated this disability) (Date injury occurred/illness began)

Physician's Address: _____ Date Treated: _____
(Date first seen by a physician)

City, State Zip: _____ Last Day Worked: _____

If injured, how: _____

Job duties you can no longer perform: _____

Are you currently employed with the Board of Education (BoE) or City? Yes ◯ No ◯

Are you currently pursuing a workers' compensation claim with the BoE or City? Yes ◯ No ◯

Have you received treatment, attention, or advice from any physician or other practitioner for, or been told by any physician or other practitioner that you have or have ever had…

High blood pressure, chest pain, or heart trouble?	Yes ◯	No ◯
Asthma, bronchitis, tuberculosis, or other disease or the lungs?	Yes ◯	No ◯
Gallstone, ulcers, or any disease of the liver?	Yes ◯	No ◯
Epilepsy, paralysis, dizziness, or any mental or nervous disorder?	Yes ◯	No ◯
Cancer or other tumor?	Yes ◯	No ◯
Arthritis or rheumatic fever, back or joint/injury?	Yes ◯	No ◯
Diabetes; disease of the kidneys?	Yes ◯	No ◯
Anemia, leukemia, or disease of the blood?	Yes ◯	No ◯
Any deformity, loss or impairment of limb, sight, or hearing?	Yes ◯	No ◯

List below all illness or injuries suffered during the past five (5) years. Provide the dates of treatment, names of physicians or practitioners involved, duration of treatment, and any other relevant information. (If more space is needed, attach sheet).

FORM #5B:
DISABILITY APPLICATION
EMPLOYEE SIGNATURE PAGE

CITY OF ATLANTA PENSION CENTER
2472 Jett Ferry Rd, Ste 400-410
Atlanta, GA 30338
Phone: (888) 594-0216
Fax: (866) 201-5033

Name of Disability Applicant:

AS PART OF THE DISABILITY APPLICATION PROCESS, DO YOU AGREE TO…

…Submit to an examination by a physician selected by the Retirement Board?	Yes ◯	No ◯
…Provide completed Employee Statement (Form #5A) to the examining physician?	Yes ◯	No ◯
…Provide a copy of your job description to the examining physician?	Yes ◯	No ◯

IF YOUR DISABILITY APPLICATION IS APPROVED, DO YOU AGREE TO…

…If requested, be re-examined by the Board's physician at least once a year?	Yes ◯	No ◯
…Inform the Board immediately if you are no longer disabled?	Yes ◯	No ◯
…Immediately inform the Board if you secure any type of employment and the amount of money you received?	Yes ◯	No ◯
…If requested, grant authority to the Board to examine your federal income tax return?	Yes ◯	No ◯

I hereby affirm that I am totally and permanently disabled and unable to perform my regular, assigned, or comparable duties for the City of Atlanta.

I understand that my disability benefit will stop at my normal retirement age. My retirement benefit will be calculated at that time and may be less than my disability benefit.

I hereby authorize the Board of Trustees, my plan's pension fund, their agents, servants, or employees, and employees of the City of Atlanta to have access to any information on file in governmental and/or health status pertaining to me. I do further release such trustees, agents and employees from any and all claims, actions, causes of action, and/or damages resulting from or arising out of the release of such information.

I hereby declare that all information provided by me on this form is complete, true and accurately recorded. I therefore request that I be granted a disability pension to be computed as provided by law. Such benefits to commence the day following the last day of paid employment for the City of Atlanta.

Applicant's Signature _____ Date _____

FORM #5C:
DISABILITY APPLICATION
PHYSICIAN STATEMENT

CITY OF ATLANTA PENSION CENTER
2472 Jett Ferry Rd, Ste 400-410
Atlanta, GA 30338
Phone: (888) 594-0216
Fax: (866) 201-5033

Name of Disability Applicant:

DIAGNOSIS & CONCLUSIONS

Do your records indicate any differences from the medical history/Employee Statement (Form #5A) provided by the employee? Yes ◯ No ◯

If yes, explain:

Please indicate the nature of the applicant's condition and any other information you consider pertinent:

Recommendations for future treatment/corrective surgery:

Would you classify this as a degenerative (such as cardiovascular, pulmonary or musculoskeletal) condition? Yes ◯ No ◯

Would you classify this condition as resulting from the aggravation of a pre-existing physical or mental defect, disease (functional or organic) or deformity? Yes ◯ No ◯

Of the job duties listed in the attached job description, in your opinion, which is the employee able to perform without limitation?

AFFIDAVIT OF PHYSICIAN

I have reviewed the above-named Disability Applicant's job description and my opinion is that he/she… (choose one)
…totally and permanently disabled and unable to perform his/her regular or comparable duties for the Board of Education/City of Atlanta.

☐ IS
☐ IS NOT

This person has been totally and permanently disabled since: _____
(Date or "N/A" if not disabled)

Examining Physician's Signature _____ Date _____

Examining Physician's Printed Name _____ Phone Number _____

Street Address _____ City, State Zip Code _____

RETURN THIS PHYSICIAN STATEMENT TO THE CITY OF ATLANTA PENSION CENTER USING THE ADDRESS OR FAX NUMBER AT THE TOP OF THIS FORM.

O.C.G.A. §50-36-1(e)(2) Affidavit

By executing this affidavit under oath, as an applicant for a City of Atlanta Pension Refund, Withdrawal, Hardship or other public benefit as referenced in O.C.G.A. §50-36-1, I am stating the following with respect to my application for a City of Atlanta public benefit:

For: _____
[Name of natural person applying on behalf of individual, business, corporation, partnership, or other private entity]

1)._____ I am a United States citizen.

2)._____ I am a legal permanent resident of the United States.

3)._____ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency.

My alien number issued by the Department of Homeland Security or other federal immigration agency is: _____.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. §50-36-1(e)(1), with this affidavit.

The secure and verifiable document provided with this affidavit can be best classified as:

_____.

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. §16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in _____ (city), _____ (state).

_____
Signature of Applicant

_____
Printed Name of Applicant

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE
_____ DAY OF _____, 20__.

_____
NOTARY PUBLIC
My Commission Expires: _____