**TEACHERS' RETIREMENT BOARD**
165 Capitol Avenue
Hartford, CT 06106-1673

Toll free: 1 (800) 504-1102
Website: portal.ct.gov/trb

**DISABILITY APPLICATION FORM**

# APPLICATION FOR DISABILITY ALLOWANCE SECTION SUMMARY

| | |
|---|---|
| **Section I:** | Member Demographic Information |
| **Section II:** | Election of Supplemental and/or Voluntary Accounts |
| **Section III:** | Physician Information |
| **Section IV:** | Beneficiary Designation for Disability Allowance |
| **Section V:** | Survivorship Benefits – Settlement Information |
| **Section VI:** | Member's Personal Statement for Disability Allowance |
| **Section VII:** | Personal Physician's Authorization Form and Medical Report |
| **Section VIII:** | Human Resource Statement for Disability Allowance |
| **Section IX:** | Tax Withholding Elections |
| **Section X:** | Electronic Funds Transfer (EFT) Authorization Form |

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# APPLICATION FOR DISABILITY ALLOWANCE

## I: MEMBER DEMOGRAPHIC INFORMATION

| | | | | |
|---|---|---|---|---|
| MEMBER FIRST NAME | MEMBER LAST NAME | | M.I. | SOCIAL SECURITY # |
| ADDRESS | | | | DATE OF BIRTH |
| CITY | STATE | ZIP | EMAIL | |
| PHYSICAL ADDRESS (If above address is a P.O. Box) | | | | |
| CITY | STATE | ZIP | PHONE | |

## II: ELECTION OF SUPPLEMENTAL AND/OR VOLUNTARY ACCOUNTS

**Check one category for each Account you have.** If in doubt, refer to your annual statement.

| Account Type | Refund/Rollover* | Extra Annuity |
|---|---|---|
| 1% Supplemental | ☐ | ☐ |
| Voluntary | ☐ | ☐ |

* If you elect the lump sum option, additional information will be sent to you regarding the distribution of the account(s).

## III: PHYSICIAN INFORMATION

**LIST ALL PHYSICIANS WHO WILL BE PROVIDING MEDICAL REPORTS TO TRB. ALL REPORTS MUST BE RECEIVED BEFORE YOUR CASE WILL BE REVIEWED.**

| Physician's name | Address | Telephone |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Under current laws and regulations, medical insurance is available with your last employing Board of Education until you are enrolled in Medicare A and B, at which time Medicare insurance plans are available through Teachers' Retirement.

**Certification Statement:**
I understand I am required to report all earned income, Social Security and Worker's Compensation Benefits to the Teachers' Retirement Board and submit periodic medical reports when requested and that failure to comply will result in discontinuation of my disability allowance.

**Applicant's Signature** **Date**

**DISABILITY APPLICATION FORM**
**Member SSN or TRB #:**

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# IV: BENEFICIARY DESIGNATION FOR DISABILITY ALLOWANCE

**MEMBER INFORMATION:**

| MEMBER FIRST NAME | MEMBER LAST NAME | MEMBER M.I. | PHONE NUMBER | SOCIAL SECURITY # |
|---|---|---|---|---|
| STREET ADDRESS | | | EMAIL | |
| CITY | STATE | ZIP | CHECK IF: NEW ADDRESS ☐ NAME CHANGE ☐ | |

I hereby revoke any previously recognized beneficiary designation and elect to name the following individual(s) as my designated beneficiary(ies). I understand that under the terms and conditions of Payment Plan N, if I expire before I have received four times the amount in my account (contributions and interest), my designated beneficiary (or estate) will receive a lump sum payment of my account balances reduced by either 25% or 50% of total benefit received. The reduction will be 25% if you have accumulated ten years of credited service in the public school system of CT prior to July 1, 2019, otherwise it will be 50%.

| **Beneficiary Designation** | ☐ Primary | ☐ Contingent | | |
|---|---|---|---|---|
| Full Name | | Relationship to Member | Social Security # | Date of Birth |
| Address | | | Email | |
| City | State | Zip | Phone | |

| **Beneficiary Designation** | ☐ Primary | ☐ Contingent | | |
|---|---|---|---|---|
| Full Name | | Relationship to Member | Social Security # | Date of Birth |
| Address | | | Email | |
| City | State | Zip | Phone | |

| **Beneficiary Designation** | ☐ Primary | ☐ Contingent | | |
|---|---|---|---|---|
| Full Name | | Relationship to Member | Social Security # | Date of Birth |
| Address | | | Email | |
| City | State | Zip | Phone | |

**DISABILITY APPLICATION FORM**
**Member SSN or TRB #:**

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# BENEFICIARY ELECTION FOR DISABILITY ALLOWANCE FORM

CTRB does not acknowledge the receipt of individual forms. Please retain a copy of this form for your records and forward it by fax or regular mail directly to CTRB at the address above.

**Important Filing Information:**
Section 10-183(h) of the Connecticut General Statutes requires that monthly survivor benefits be paid to the statutory survivors of members who die while active before any balance is paid to your designated beneficiary. This is true regardless of whom you designated as your beneficiary. A statutory survivor includes but is not limited to a spouse and/or a minor child under the age of 18. Refer to our Survivorship Benefits Before Retirement Bulletin before completing this form. This form supersedes and replaces any previous beneficiary designations. All items pertaining to beneficiaries must be completed in order for the Connecticut Teachers' Retirement Board (CTRB) to process the form; incomplete forms will be returned.

- Include a complete list of all beneficiaries.
- Type or print clearly in ink and do not use white out.
- Do not submit an amended copy of a previous beneficiary form.
- You may name any living person, your estate, a trust, or a charitable organization as your beneficiary.
- At least one primary beneficiary must be named. If more than one primary beneficiary is named, the share of any beneficiary who dies before you shall be divided equally among the surviving primary beneficiaries.
- Payment is made to a contingent beneficiary(ies) only if all primary beneficiaries die before you do.
- If you survive all of the beneficiaries named, payment would be issued to your estate.
- "Per Stirpes" designations (unnamed or unborn beneficiaries) are not accepted.
- All information must appear in the appropriate section of this form.
- To designate a trust as a beneficiary, enter the name and date of the trust agreement in the Beneficiary section of this form; leave the Relationship and Social Security sections of this form blank; and indicate Primary or Contingent.
- To designate your estate as a beneficiary, enter the word "Estate" in the Beneficiary section of this form; leave the Relationship and Social Security sections of the form blank; and indicate Primary or Contingent

**CTRB does not acknowledge the receipt of individual forms. Please retain a copy of this form for your records and forward it by fax or regular mail directly to CTRB at the address above.**

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# V: SURIVORVSHIP BENEFITS – SETTLEMENT INFORMATION

**Active member or CTRB Disability Allowance recipient dies PRIOR to meeting retirement eligibility requirements:**

| Spouse? | Primary Beneficiary | Minor Children? | Settlement of Account |
|---|---|---|---|
| Yes | Spouse | Yes | Surviving Spouse Benefit<br>and Minor Child Benefit |
| Yes | Other | No | Surviving Spouse Benefit |
| Yes | Spouse | No | Surviving Spouse Benefit<br>or Lump Sum Payment |
| No | Children | Yes | Minor Child Benefit |
| No | Children | No | Lump Sum Payment to Beneficiary |
| No | Other | No | Lump Sum Payment to Beneficiary |
| No | Other | Yes | Minor Child Benefit |

**Active member or CTRB Disability Allowance recipient dies AFTER meeting retirement eligibility requirements:**

| Spouse? | Primary Beneficiary | Minor Children? | Settlement of Account |
|---|---|---|---|
| Yes | Spouse | Yes | Surviving Spouse Benefit<br>or Lump Sum Payment<br>or Plan D 100% Co-participant Benefit<br>plus Minor Child Payment |
| Yes | Other | No | Surviving Spouse Benefit<br>or Lump Sum Payment<br>or Plan D 100% Co-participant Benefit |
| Yes | Spouse | No | Surviving Spouse Benefit<br>or Lump Sum Payment<br>or Plan D 100% Co-participant Benefit |
| No | Children | Yes | Minor Child Benefit |
| No | Children | No | Lump Sum Payment to Beneficiary |
| No | Other | No | Lump Sum Payment to Beneficiary |
| No | Other | Yes | Minor Child Benefit |

Retirement Eligibility Requirements:

- 10 years of CT credited service at age 60 or over.
- 20 years of credited service at age 55 (minimum 15 in CT).
- 25 years of credited service at any age (minimum 20 in CT).
- 35 years of credited service at any age (minimum 25 in CT)

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# VI: MEMBER PERSONAL STATEMENT FOR DISABILITY ALLOWANCE

You are required to submit a handwritten statement outlining the effect your illness has on your ability to perform your job duties and your day to day personal activities. Please be as specific as possible.

| Name of Applicant | Social Security # |
|---|---|
| I am applying for a Disability Allowance due to: (Please check one) | A Physical Impairment ☐ |
| | A Mental Impairment ☐ |
| | Both a Physical and a Mental Impairment ☐ |

______________________________________________________________________________

**Applicant's Signature** **Date**

**MEMBER'S PERSONAL HANDWRITTEN STATEMENT:**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

You may add additional pages as necessary. Please do not write on the back of this form or on the back of any additional forms.

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Website: portal.ct.gov/trb



# VII: PERSONAL PHYSICAN'S AUTHORIZATION FORM AND MEDICAL REPORT

**This report should be provided to all of the physician's listed on your disability allowance application**

| | |
|---|---|
| Applicant's Name | |
| Applicant's Address | |
| Date of Birth | |

I authorize the release of my medical information in determining whether I can be considered for a disability allowance from the Connecticut Teachers' Retirement Board.

Applicant's Signature:_________________________________________________Date:________________________

**Physician:**
Please mail or fax this medical report, including all office notes, to CTRB, 765 Asylum Avenue, Hartford, CT 06105-2822.
Please do not write on the back of this form or on the back of any additional forms.

| |
|---|
| Office notes/records are required<br>along with the following information. |
| **1. Major Health Complaints as stated by the patient** |
| **2. Past Medical History; include hospitalizations, laboratory findings, x-rays etc.** |
| **3. Precipitating events, including accidents** |

**4. Current history: (Please check the appropriate categories)**

| | | |
|---|---|---|
| ☐ Extremities and Back | ☐ Peripheral Spinal Nerves | ☐ Central Nervous System |
| ☐ Respiratory System | ☐ Cardiovascular System | ☐ Hematopoietic System |
| ☐ Visual System | ☐ Ear, Nose, Throat | ☐ Digestive System |
| ☐ Reproductive/Urinary System | ☐ Endocrine System | ☐ Skin |
| ☐ Mental Illness | | |

**5. Describe Symptoms and Signs, onset and duration**:

**6. Abnormal Physical Findings:**

**7. Diagnosis and Degree of Impairment of function**

**8. Course of treatment, Current Treatment plan, Patient Response**

**9. Current Medications**

**10. Clear Statement Regarding "Disabled" Status**

| | |
|---|---|
| Name of Physician(Signature)/Date: | |
| Name of Physician(Type or Print): | |
| Physician's Specialty: | |
| Connecticut Medical License #: | |

**DISABILITY APPLICATION FORM**
**Member SSN or TRB #:**

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# VIII: HUMAN RESOURCE STATEMENT FOR DISABILITY ALLOWANCE

Date: ________________________________

From: ____________________________________________________________________________________
Name of Applicant Social Security Number Employer

To: ____________________________________________________________________________________
Name of Human Resource Director

I am applying to the Connecticut Teachers' Retirement Board for Disability. I authorize you to submit a statement to Connecticut Teachers' Retirement Board. This statement should include background information such as days missed from school, any pending workers' compensation claims, any short or long term disability insurance claims.

____________________________________________________________________________________
**Applicant's Signature** **Date**

**HUMAN RESOURCE DIRECTOR: (PLEASE PROVIDE THE FOLLOWING INFORMATION)**

1. Please provide the attendance records of the applicant for the past 24 months;

2. Is the applicant able to perform the essential functions of their assigned position?
☐ Yes ☐ No
If no, please provide a list of the essential functions they are unable to perform

3. Is the applicant receiving workers' compensation benefits? ☐ Yes ☐ No

4. Is the applicant receiving any board provided short or long term disability? ☐ Yes ☐ No

____________________________________________________________________________________
**Signature of Human Resource Director** **Date**

**TO Human Resource Director:**
Please complete this form and mail or FAX directly to this office. You may add additional pages as necessary. Please do not write on the back of this form or on the back of any additional forms.

**DISABILITY APPLICATION FORM**
**Member SSN or TRB #:**

Department of Revenue Services
State of Connecticut
(Rev. 12/23)

# Form CT-W4P

## Withholding Certificate for Pension or Annuity Payments

**2024**

**Purpose:** Form CT-W4P is for Connecticut resident recipients of pensions, annuities, and certain other deferred compensation, to tell payers the correct amount of Connecticut income tax to withhold. Your options depend on whether the payment is periodic or nonperiodic. Read the instructions on Page 2 before completing this form.

**Instructions for Periodic Payments, such as a monthly pension payment:**

**Step 1:** (Required) Select the filing status and description of income from the chart below that best matches your situation. Enter the corresponding Withholding Code on Line 1.

Step 2: (Optional) To see the amount of tax that will be withheld monthly, see the *Monthly Connecticut Withholding Calculator* in **myconneCT** at **portal.ct.gov/DRS-myconneCT**.

Step 3: (Optional) To increase or decrease the amount that will be withheld, enter an additional amount on Line 2, or a reduction amount on Line 3.

**Instructions for Nonperiodic Payments, such as an on demand distribution:** Do **not** use the chart below. Either enter *Withholding Code* “E” on Line 1 which will result in $0 withholding; **or** enter *Withholding Code* “E” on Line 1 and a dollar amount on Line 2 for a specific amount to be withheld. If neither of these options are indicated, your payer will withhold at 6.99%.

| Married Filing Jointly | Withholding Code |
|---|---|
| Our expected combined annual gross income is **less** than or equal to $24,000 **or** no withholding is necessary (i.e., withholding from other income source). | **E** |
| My spouse **has** income subject to withholding and our expected combined annual gross income is **greater** than $24,000 and less than or equal to $100,500. | **A** |
| My spouse **does not** have income subject to withholding and our expected combined annual gross income is **greater** than $24,000. | **C** |
| My spouse **has** income subject to withholding and our expected combined annual gross income is **greater** than $100,500. | **D** |
| I have significant other income and wish to avoid having too little tax withheld. | **D** |

| Married Filing Separately | Withholding Code |
|---|---|
| My expected annual gross income is **less** than or equal to $12,000 **or** no withholding is necessary (i.e., withholding from other income source). | **E** |
| My expected annual gross income is **greater** than $12,000. | **A** |
| I have significant other income and wish to avoid having too little tax withheld. | **D** |

| Single | Withholding Code |
|---|---|
| My expected annual gross income is **less** than or equal to $15,000 **or** no withholding is necessary (i.e., withholding from other income source). | **E** |
| My expected annual gross income is **greater** than $15,000. | **F** |
| I have significant other income and wish to avoid having too little tax withheld. | **D** |

| Qualifying Surviving Spouse | Withholding Code |
|---|---|
| My expected annual gross income is **less** than or equal to $24,000 **or** no withholding is necessary (i.e., withholding from other income source). | **E** |
| My expected annual gross income is **greater** than $24,000. | **C** |
| I have significant other income and wish to avoid having too little tax withheld. | **D** |

| Head of Household | Withholding Code |
|---|---|
| My expected annual gross income is **less** than or equal to $19,000 **or** no withholding is necessary (i.e., withholding from other income source). | **E** |
| My expected annual gross income is **greater** than $19,000. | **B** |
| I have significant other income and wish to avoid having too little tax withheld. | **D** |

Submit completed form to the payer of your pension or annuity, **not** DRS.

Department of Revenue Services
State of Connecticut

**Withholding Certificate for Pension or Annuity Payments**

**2024 Form CT-W4P**

**Complete the following applicable lines.**

**1.** Withholding Code: See instructions above. .......... **1.** ________

**2.** Additional withholding amount per payment, if any. .......... **2.** $ ________

**3.** Reduced withholding amount per payment, if any. .......... **3.** $ ________

| First name / MI / Last name | Social Security Number |
|---|---|
| | |
| Home address (number and street, apartment number, suite number, PO Box) | Claim or identification number (if any) of your pension or annuity contract |
| City/town / State / ZIP code | |

☐ I hereby certify that I am no longer a Connecticut resident. Please cancel my CT withholding.

**Declaration**: I declare under penalty of law that I have examined this certificate and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for reporting false information is a fine of not more than $5,000, imprisonment for not more than five years, or both.

| Payee’s signature | Date |
|---|---|
| | |



Visit us at **portal.ct.gov/DRS** for more information.

# Form CT-W4P Instructions

## Payee General Instructions

**Form CT-W4P**, *Withholding Certificate for Pension or Annuity Payments*, is for Connecticut resident recipients of pension, annuities and certain other deferred compensation subject to Connecticut income tax. Form CT-W4P provides your payer with the necessary information to withhold the correct amount of Connecticut income tax from your pension or annuity payment to ensure that you will not be underwithheld or overwithheld.

Payers of taxable pension or annuity distributions are required to deduct and withhold income tax from such distributions. Distributions subject to withholding include taxable distributions from the following: an employer pension, and annuity, a profit sharing plan, a stock bonus, a deferred compensation plan, an individual retirement arrangement (IRA), an endowment and a life insurance contract. Taxable distributions are distributions that are subject to federal income tax. Non-taxable distributions (for example, most distributions from Roth 401(k) or Roth IRA accounts) are not subject to withholding. Form CT-W4P is not required for non-taxable distributions.

The method of withholding depends on whether the payment is periodic, nonperiodic, or a distribution of the entire account balance. Connecticut uses the federal definition for periodic and nonperiodic payments.

**Periodic Payments:** Withholding from periodic pension and annuity payments, such as monthly pension payments, is calculated using the same method that an employer uses to determine the amount to withhold from wages.

**Determining your withholding code:** When completing Form CT-W4P, you must first determine your withholding code. Your withholding code is based on the filing status you expect to report on your Connecticut income tax return and the statement that best describes your annual gross income.

Your annual gross income is your total income from all sources. In calculating your total income from all sources, you may deduct 100% of the income received from certain pensions and annuities, such as from a defined benefit plan, 401(k), 403(b) plans as follows:

- For single, married filing separately, or head of household filers with federal adjusted gross income (AGI) for the taxable year of less than $75,000. For federal adjusted gross income at least $75,000 but less than $100,000, the deduction is gradually phased out until it is fully phased out at $100,000 for these filers.
- For married filing jointly or qualifying surviving spouse filers with federal adjusted gross income (AGI) for the taxable year of less than $100,000. For federal adjusted gross income at least $100,000 but less than $150,000, the deduction is gradually phased out until it is fully phased out at $150,000 for these filers.
- *In the case of the IRA deduction (other than Roth IRAs), the deduction calculated above applies to 50% of the IRA income.*

For more information, see **Informational Publication 2024(7),** *Is My Connecticut Withholding Correct?*

- If you receive payments from the Teachers' Retirement System, exclude 50% of the amounts received. If your federal AGI is below the applicable threshold you may claim either the teachers' pension subtraction modification or the pension and annuity subtraction modification, whichever is greater.

Failure to give your payer a properly completed Form CT-W4P will result in 6.99% withholding from your payment(s).

**Nonperiodic Payments:** Your payer must withhold 6.99% from the taxable amount of nonperiodic payments (see *Distribution of the entire account balance*, on this page) **unless** you complete Form CT-W4P using one of the following options. Distributions from an IRA that are payable on demand are treated as nonperiodic payments. Do **not** use the chart on Page 1. Either enter:

- *Withholding Code* "E" on Line 1 which will result in $0 withholding; **or**
- *Withholding Code* "E" on Line 1 and a dollar amount on Line 2 for a specific amount to be withheld.

You may not choose any other withholding code.

Form CT-W4P will remain in effect until you submit a new one. You should complete a new Form CT-W4P if your tax situation changes, such as your filing status changes. You should furnish your payer with a new Form CT-W4P.

**Distribution of the entire account balance:** The withholding rate for lump sum distribution of the entire account balance is 6.99% without allowance for exemption, unless any portion of the lump sum distribution was previously subject to tax (distributions from Roth 401(k) or Roth IRA accounts), or the lump sum distribution is a trustee-to-trustee transfer, or is a direct roll over in the form of a check made payable to another qualified account. You cannot claim exemption from withholding. Don't give Form CT-W4P to your payer.

## Check Your Withholding

You may be underwithheld if any of the following apply:

- You have more than one source of income;
- If your filing status is married filing jointly and you or your spouse, or both, have more than one source of income; **or**
- You have substantial other income such as interest, dividends or capital gains.

If you are underwithheld, you should consider adjusting your withholding or making estimated payments using **Form CT-1040ES**, *Estimated Connecticut Income Tax Payment Coupon for Individuals*.

If you owe $1,000 or more in Connecticut income tax over and above what has been withheld from your income for the prior taxable year, you may be subject to interest on the underpayment at the rate of 1% per month or fraction of a month.

To help determine if your withholding is correct, see *Is My Connecticut Withholding Correct?*

## Payer Instructions

For any payee who does not complete Form CT-W4P, you are required to withhold at the highest marginal rate of 6.99% without allowance for exemption from any taxable distribution. You are required to keep Form CT-W4P in your files for each payee.

For additional instructions, see *Connecticut Tax Guide for Payers of Nonpayroll Amounts*.

**TEACHERS' RETIREMENT BOARD**
165 Capitol Avenue
Hartford, CT 06106-1673

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Website: portal.ct.gov/trb



# FEDERAL TAX WITHHOLDING CHANGE FORM

**A separate form must be submitted for each monthly benefit you get from TRB**

| | | | |
|---|---|---|---|
| **Name (please print)** | | | **Social Security #** |
| **Address Line 1 (Check box if this is an Address Change)** ☐ | | | **Address Line 2** |
| **City** | **State** | **Zip** | **Email (Check box if this is an Email Change)** ☐ |
| **Telephone** | | | **Cell Phone** |
| **If getting multiple benefits from TRB, specify which benefit this form applies to:** ☐ Member Benefit ☐ Survivorship Benefit ☐ QDRO Benefit | | | |
| ☐ **I am no longer a resident of Connecticut. Please cancel my CT withholding.** | | | |
| ☐ **I do not want federal income tax withheld from my CTRB Benefit. This does not release you from the liability for any federal income tax due.** | | | |

## Step 1: Federal Withholding

☐ **Single** or **married filing separately**
☐ **Married filing jointly** or **qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

**Complete Steps 2–4 ONLY if they apply to you**. Visit www.irs.gov/pub/irs-pdf/fw4p.pdf for detailed instructions and worksheets for completing tax withholding information.

## Step 2: Income From a Job or Multiple Pensions/Annuities (Including a Spouse's Job or Pension/Annuity)

Complete this step if you (1) receive income from a job or more than one pension/annuity, or (2) are married filing jointly and your spouse receives income from a job or a pension/annuity.

Complete the items below.

i) If you (or your spouse) have a job(s), enter the total taxable annual pay from all job(s) and any other income entered on Form W-4, Step 4(a), less the deductions entered on Form W-4, Step 4(b). If you (or your spouse) do not have a job(s), enter "-0-" . . . . . . . . . . . . . . $_______________

ii) If you (or your spouse) have another pension/annuity that pays less annually than this pension/annuity, enter the total annual taxable payments from those other sources. If this is the only pension/annuity or it pays the least taxable amount annually, enter "-0-" . . . . . $_______________

iii) Add the amounts from items (i) and (ii) and enter the total here . . . . . . . . . . . . . . . . . . . . . . . . . $_______________

**TIP:** To be accurate, submit a 2024 Form W-4P for all other pensions/annuities. Submit a new Form W-4 for your job(s) if you have not updated your withholding since 2019.

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If you (or your spouse) have a job, do not complete Steps 3–4(b) on this form.

If you (or your spouse) do not have a job, complete Steps 3–4(b) for only the pension/annuity that pays the most annually.

Leave those steps blank for the other pensions/annuities.

| | | |
|---|---|---|
| **Step 3: Claim Dependent and Other Credits**<br><br>If your total income will be $200,000 or less ($400,000 or less if married filing jointly):<br>Multiply the number of qualifying children under age 17 by $2,000. . . . . . $_______________<br>Multiply the number of other dependents by $500. . . . . . . . . . . . . . . . . . . .$_______________<br>Add other credits, such as foreign tax credit and education tax credits. . . . . $_______________<br>Add the amounts for qualifying children, other dependents, and other credits and enter the total here . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | 3 | $_______________ |
| **Step 4 (optional): Other Adjustments**<br>a) **Other income (not from jobs or pension/annuity payments).** If you want tax withheld on other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, taxable Social Security and dividends . . . . . . | 4(a) | $_______________ |
| b) **Deductions.** If you expect to claim deductions other than the basic standard deduction and want to reduce your withholding, use the Deductions Worksheet from www.irs.gov/pub/irs-pdf/fw4p.pdf and enter the result here . . . . . . . . . . . . . . . . . . . . . . . . . | 4(b) | $_______________ |
| c) **Extra withholding.** Enter any additional tax you want withheld from each payment . . . . . . | 4(c) | $_______________ |

| **Monthly Benefit Recipient's Signature** | **Date** |
|---|---|
| | |

*CTRB does not acknowledge the receipt of individual forms. CTRB must receive the completed form by the 1st of the month in order for the change to be effective at the end of the month. (Benefits for the month are issued on the last business day of that month.) We require that the net monthly amount payable to the member be at least $10 after all deductions.*

*This form supersedes and replaces any previous withholding elections, including extra withholdings.*

**Please submit form to**:
165 Capitol Avenue
Hartford, CT 06106
**You may also Fax to**: (860) 525-6018

This form will be denied under the following circumstances:

1. SSN Missing or not matching TRB records.
2. Filing Status is not checked.
3. Receiving multiple benefits from TRB, but benefit type not elected.
4. Totals in Steps 2 and 3 don't add up.
5. Step 2b(i) is filled and steps 3 through 4b are non-zero. These must be reported on the W4 filled in for your Employer.
6. Signature and/or date missing.

**TEACHERS' RETIREMENT BOARD**
165 Capitol Avenue
Hartford, CT 06106-1673

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Website: portal.ct.gov/trb



# X: ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

I authorize the CTRB to initiate the electronic deposit of my monthly recurring benefits into my personal account at a financial institution that is a participating member of the National Clearing House Association (NACHA). I understand that this bank account must be a personal bank account and not a business, trust or other form of account.

I also understand that by electing an electronic deposit of my benefit I will get a statement from the CTRB only when my monthly net benefit changes, rather than a monthly statement. The statement will denote the change including but not limited to changes in tax deductions or health insurance premiums thereby enabling me to account for all benefit activity.

This authorization applies to all monthly payments by the CTRB including retirement benefits, survivorship benefits, and disability allowances. In the event of my death, I authorize my estate to reimburse CTRB for any amounts which I was not entitled to receive, and which were deposited following my death.

| | | | |
|---|---|---|---|
| Member ID Number | Beneficiary Date of Birth | | Email Address |
| Benefit Recipient's First Name | Benefit Recipient's Last Name | | Social Security Number |
| Note: Health Plan Participants – A physical address is required if providing a PO Box | | | |
| Address Line 1 | Address Line 2 | | |
| City | State | Zip | Home Phone |
| Physical Address Line 1 | Physical Address Line 2 | | |
| City | State | Zip | Cell Phone |

**MUST BE A PERSONAL BANK ACCOUNT OF THE MONTHLY BENEFIT RECIPIENT OR THE MONTHLY BENEFIT RECIPIENT'S LEGAL DESIGNEE (CONSERVATOR OR POA); MAY NOT BE A BUSINESS, TRUST, OR OTHER FORM OF ACCOUNT.**
**ATTACH A VOIDED CHECK WHICH INCLUDES THE BANK NAME, ACCOUNT HOLDERS' NAME, ROUTING NUMBER, AND ACCOUNT NUMBER OR HAVE THE FINANCIAL INSTITUTION COMPLETE THE FOLLOWING:**

*Financial Institution must be a participating member of the National Automated Clearing House Association (NACHA).*

| | | | |
|---|---|---|---|
| Routing Transit Number (Not to exceed 9 digits) | | | Bank Account Number (Not to exceed 17 digits) |
| Account Holder (*must be or include Monthly Benefit Recipient's name*) | | | Bank Account Type (select one): Checking ☐ Savings ☐ |
| Name of Financial Institution | | | |
| Street Address | | | |
| City | State | Zip | Phone |
| Signature of Bank Representative | | | Date Signed |

☐ Check this box and sign under Monthly Benefit Recipient's signature above to decline EFT; CTRB will mail a paper check to the address on our records.

*CTRB does not acknowledge the receipt of individual forms. CTRB must receive the completed form by the 1st of the month in order for the change to be effective at the end of the month. (Benefits for the month are issued on the last business day of that month.) We require that the net monthly amount payable to the member be at least $10 after all deductions.*

**DISABILITY APPLICATION FORM**
**Member SSN or TRB #:**

## Electronic Funds Transfer (EFT)

**What is it?**
Electronic Funds Transfer (EFT) is a system which electronically deposits your net benefit payment into your personal checking or statement savings account.

**Why should I participate?**
EFT enables the Monthly Benefit Recipients to receive their benefit payment on the last business day of each month. Because the payment is electronically deposited in your account, this eliminates the need to make a deposit in person. EFT also safeguards against theft, loss, misdirected mail and forgery.

**Where can you deposit my benefit?**
An EFT deposit can be made to your personal checking or statement savings account. Your bank must be a participating member of the National Automated Clearing House Association (NACHA). Most banks, savings and loan associations and credit unions participate.

**What will be deposited?**
Your net benefit payment will be deposited. Your gross benefit, deductions and any cost of living increases will be calculated exactly the same way.

**How do I enroll for EFT deposits?**
Simply fill out the upper portion of the Electronic Funds Transfer (EFT) Authorization and attach a voided check or fill out the upper portion of the form and then forward the form to an officer of your bank for completion. This completed form must then be submitted to the Teachers' Retirement Board for processing.

**How long does it take to get EFT started?**
If we receive the completed EFT form by the first of the month, your EFT payment will begin at the end of the month.

**What happens if I change banks?**
A new EFT form must be submitted.

**What happens if I change my account with the same bank?**
You must provide CTRB with your new account number ***in writing by the first of the month.*** The EFT deposit will be made to the new bank account at the end of the month.

**Will I receive any type of notice from TRB of the EFT deposit?**
You will receive a statement from this office when your EFT is initiated. You will also receive a statement when there is a financial change on your account (i.e.: taxes, cost-of-living adjustment). A statement will not be issued, however, for non-financial changes such as a bank and/or bank account number change.

**Will I continue to receive correspondence, newsletters and tax information if I sign up for EFT?**
Yes. All mailings will be issued to your home address on our records. As always, it is important that you keep us informed of any changes to your home address in writing.

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**DISABILITY APPLICATION FORM**

# APPLICATION FOR A DISABILITY ALLOWANCE

**ELIGIBILITY REQUIREMENTS**

- You cannot perform the duties of your assigned job due to physical or mental impairment.
- You are ACTIVE with your last employing Connecticut board of education, including up to ten months of current leave of absence where mandatory contributions were remitted; purchased prior Connecticut teaching service previously withdrawn, and time while out on workers compensation provided the mandatory contributions were remitted.
- You have five years of credited service in the public schools of Connecticut, for a non-service related claim.
- You are <u>not</u> eligible to receive normal benefits. (35 years of service, at least 25 years are CT service, or 20 years of CT service at age 60).

**FILING REQUIREMENTS**

**The following items must be received before your claim is placed on the Medical Review Committee agenda:**

1) Medical Reports and office notes from your physician(s)
2) Statement from Human Resources regarding work performance and attendance records
3) A handwritten statement from you outlining the effect your illness has on your ability to perform your job duties.

**Your completed application for a disability allowance is due in this office prior to the effective date of your disability allowance.**

4) Application for Disability Allowance
5) Beneficiary Designation Form.
6) Birth Certificate (Photocopy acceptable).

**ELECTION OF SUPPLEMENTAL and/or VOLUNTARY ACCOUNTS**

Members who were employed prior to June 1989 may have a 1% Supplemental account. Those members who paid additional monies into the system have a Voluntary Account. Your choices for distribution are:

- Refund/Rollover. Funds may be refunded directly to you, in which case, any pre-tax contributions and interest will become taxable. Alternatively, pre-tax contributions and interest may be rolled over into another "qualified plan", such as an IRA. The paperwork for the refund/rollover option will be mailed to you after the effective date of your disability allowance. Failure to return the paperwork for the refund/rollover option on a timely basis will result in your funds being refunded directly to you which may result in federal or state tax liabilities and related penalties.

- Extra Annuity. In lieu of receiving your 1% Supplemental and/or Voluntary account in a lump sum, you may elect to increase your monthly payment with an additional fixed annuity based on your account balance and age annuity rates in effect at the time of your disability effective date. These fixed payments are excluded from cost of living increases. Funds to be used for the purchase of an extra annuity must be received by the Teachers' Retirement Board no later than the effective date of your disability allowance.

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**CTRB DISABILITY REVIEW PROCESS**

Our Medical Review Committee (panel of licensed private doctors) reviews the medical evidence and required statements. They forward a recommendation to the Teachers' Retirement Board. The Committee meets on the first Tuesday of every month (excluding August). All items to be reviewed must be received by this office no later than the 18th of the month prior to the meeting date. When the 18th of the month falls on a weekend or State holiday, the deadline becomes the first business day following the 18th. After the MRC meeting, you will receive written notification of the results of the meeting, and if approved, an Effective Date Election Form for your immediate completion.

The disability income will cease when the disability ends. The Board may call upon the member to submit periodic medical reports, and determine that a member's disability has ended if it finds that the member has failed to pursue an appropriate program of treatment.

Disability benefits will be calculated at 2% of your final salary base (average of highest three paid salaries) times the years of full-time credited service, subject to a maximum benefit of 50% of final average salary, and minimum benefit of 15% of final average salary (for 7.5 or fewer years of service). Additional Service Credit purchased within five years of the effective date of disability is excluded.

**OFFSETS AGAINST INCOME WHILE COLLECTING A DISABILITY ALLOWANCE**

During the first twenty-four months, twenty percent of any earned income or wages shall be subtracted from the disability allowance payable unless the Board determines that such earned income is being paid as part of the rehabilitation of the member.

After the first twenty-four months, your disability allowance and your earned income can equal the "final average salary" we used to compute your disability allowance. All earnings in excess of this amount are subtracted from your disability allowance.

A dollar for dollar offset will apply if the total of the disability allowance, less cost of living adjustments plus any initial award of social security benefits or worker's compensation, exceeds seventy-five percent of the member's final average salary.

**TWENTY FOUR MONTHS LATER**

After twenty four months of disability allowance payments, you will be required to submit new medical documentation. To be eligible for a continued disability allowance, additional medical documentation must be provided to substantiate that you do not have the ability to engage in any substantial gainful activity.

**CONVERSION OF BENEFIT**

Service credit will accrue to a maximum of 30 years while receiving disability allowance. Upon the attainment of age 60 (or older) with a minimum of 20 years of CT credited service (including accrued service), the disability allowance will be converted to a normal retirement benefit. You will be required to select a payment plan and your converted benefit will include any cost of living adjustments accrued while on disability.

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# HEALTH INSURANCE

## Disability with Public School Service:

**Pre-Medicare:** If you are receiving disability before you become eligible for Medicare you may continue to obtain insurance coverage through your last employing board of education. This option is also available to your Spouse or Surviving Spouse; or to a disabled dependent if at least one parent is deceased. A subsidy payment is sent directly to your Board of Education to offset your monthly out of pocket cost for your health insurance premium, your Spouse's health insurance premium or a disabled dependent's health insurance premium if there is no Spouse. Should the TRB member pass away, a surviving Spouse who has not remarried or a disabled dependent retains eligibility for this insurance coverage or the TRB Health Benefits for their lifetime.

Disability recipients whose last employer is the State of Connecticut should check with their Human Resource (HR) department for eligibility requirements and to obtain the necessary forms and instructions on how to enroll or remain enrolled in the State Employee health insurance plan.

Eligibility for the State Employees health insurance program for a surviving spouse of a TRB member is linked to receiving a monthly retirement benefit.

Eligibility for the Teachers' Retirement Board health insurance program for a surviving spouse of a TRB member is not linked to receiving a monthly retirement benefit.

A surviving spouse who remarries is not eligible for either the State Employees or the Teachers' Retirement Board health insurance program.

## For All Disability Recipients who are Medicare Eligible:

Once you, your Spouse or surviving Spouse (or a disabled dependent if there is no Spouse or surviving Spouse) are participating in Medicare Part A and Part B you will have the option to enroll in either a Medicare Advantage plan or traditional Supplement plan administered by the Connecticut Teachers' Retirement Board. The required enrollment application may be obtained from our website under the health insurance section at portal.ct.gov/trb. ***The TRB Sponsored Health Insurance Application must be submitted 30 days prior to the effective date of coverage (e.g., June 1st for coverage to be effective July 1st).*** A surviving Spouse becomes ineligible for this plan upon remarriage.

Premiums for the CTRB sponsored Medicare Advantage or traditional Supplement plan are deducted from the TRB member's disability benefit. Premiums are deducted one pay period in advance to cover the enrollee for the upcoming month. Enrollees will have a retro deduction taken from their first or second payment until the premium balance is current.

Spouses are eligible to enroll in the CTRB sponsored health plan option if they are Medicare eligible, even if the Disability recipient is not yet 65 or enrolled in Medicare.

You, your Spouse or Surviving Spouse; or a disabled dependent if there is no Spouse or Surviving Spouse, may continue coverage with the board of education if they are not eligible for Medicare or do not have enough quarters to qualify for Premium Free Medicare Part A. A subsidy payment increase is available for those members and their spouses who are over age 65 and unable to participate in Medicare. You can learn more by visiting the FAQs of our Health Insurance section on the CTRB website.

## Health Insurance Frequently Asked Questions

Answers to frequently asked questions about our Medicare plans and health insurance obtained through the last employing school district.

https://portal.ct.gov/trb/content/health-insurance/health-insurance-menu/faqs