



Retirement or DROP Application

For State Police

MEMBER'S NAME (LAST, FIRST, M.I.)	MEMBER ID OR SSN	DAYTIME TELEPHONE ()
MAILING ADDRESS		DATE OF BIRTH
CITY, STATE, ZIP CODE		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE

Use this form to apply for a service retirement or the Deferred Retirement Option Plan (DROP) with the State Police Retirement System. Before completing each of the following sections, read through that section's instructions.

Section I: Retirement Information

I wish to apply for a: Deferred Retirement Option Plan (DROP) - Complete Section II ONLY.
 Retirement - Complete Section III, IV, V, and VI.

As the result of a divorce, I have an acceptable Eligible Domestic Relations Order (EDRO) on file with ORS, which divides my pension benefit. NO YES (Any EDRO must be on file with ORS before the retirement effective date.)

Section II: Deferred Retirement Option Plan

To participate in the Deferred Retirement Option Plan (DROP), you must meet the following eligibility criteria.

- Be actively employed and have 25 or more years of credited service under the State Police Retirement System.
- File this DROP application form between 30 and 90 days before your retirement effective date, which is the date you would cease being an active member of this retirement system and become a DROP participant.

DROP Participation Period: Begin Date: _____ End Date: _____ (Retirement Effective Date)
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Beneficiary Designation for the DROP Account. If you wish to name someone other than your pension beneficiary to receive the balance of your DROP account at the time of your death, complete the following.

DROP ACCOUNT BENEFICIARY NAME	RELATIONSHIP TO MEMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ADDRESS, CITY, STATE, ZIP	SOCIAL SECURITY NUMBER	BIRTH DATE

Applicant's Certification

I certify I am retiring from active membership in the State Police Retirement system as of the retirement effective date indicated above and am electing to participate in the Deferred Retirement Option Plan (DROP) for the time period designated. I understand I will begin my retirement at the end of my DROP participation period. Once ORS accepts this application my participation in the DROP is irrevocable.

Applicant Signature: _____ Date: _____

Section III: Retirement

ORS must receive your completed application form at least 30 days, but no more than 90 days before your retirement effective date. Your retirement effective date is the first day of the month following your last day on payroll with the State Police.

Retirement Effective Date: My retirement effective date is the first of _____, 20____

By my signature below, I certify I am a member of the State Police Retirement System and wish to apply for retirement from service with the Michigan State Police. I also authorize the selections made in the following Income Tax Withholding Authorization and my designation(s) for Electronic Funds Transfer. By using EFT, I authorize ORS to recover money electronically deposited in my account(s) in error, either by adjusting the account(s) or withholding any future payments. I understand I will be notified in writing if adjustments are made.

Applicant Signature: _____ Date: _____



Name: _____
 SSN or Member ID: _____
 Address _____
 City _____
 State _____ Zip _____

ORS State Police
Retirement Application (continued)

EFFECTIVE DATE		
H	/	/
VBR	/	/
DDR	/	/

Section IV: Insurance Options (Must complete and sign even if declining insurances.)

A. Decline or Enroll Options

If you are declining coverage at this time, check the DECLINE box(es) below. Then sign in Section D.

If enrolling, please check the "enroll" box for the provider you are selecting. You can select from either BCBSM or an HMO for your health care coverage. Indicate the date when you want each insurance to be effective. Effective dates are always the first of the month.

	ENROLL	DECLINE	EFFECTIVE DATE	CHECK THE APPROPRIATE BOX(ES) FOR WHO IS TO BE COVERED.
BCBSM	<input type="checkbox"/>	<input type="checkbox"/>	/01/	<input type="checkbox"/> SELF <input type="checkbox"/> SELF & SPOUSE <input type="checkbox"/> SELF & CHILD(REN) <input type="checkbox"/> FULL FAMILY
HMO	<input type="checkbox"/>	<input type="checkbox"/>	/01/	Please obtain and enclose completed HMO application.
DENTAL PLAN	<input type="checkbox"/>	<input type="checkbox"/>	/01/	<input type="checkbox"/> SELF <input type="checkbox"/> SELF & SPOUSE <input type="checkbox"/> SELF & CHILD(REN) <input type="checkbox"/> FULL FAMILY
VISION PLAN	<input type="checkbox"/>	<input type="checkbox"/>	/01/	<input type="checkbox"/> SELF <input type="checkbox"/> SELF & SPOUSE <input type="checkbox"/> SELF & CHILD(REN) <input type="checkbox"/> FULL FAMILY

B. Enrollment Data (For you and family members you are covering.)

Complete the following information for you and all covered dependents. Attach additional pages if necessary. Report Medicare information below for anyone covered by your insurance plan(s). **You must submit proof(s) of dependency or age for each enrolled dependent.** See Final Steps in the instructions for what proofs to include with this application.

Enrollee Name (Last, First, Middle)	Medicare Claim # or Social Security #	Effective Dates On Medicare Card		Sex (M/F)	Birth Date (Mo/Day/Yr)
		Hospital—Part A	Medical—Part B		
SELF					
SPOUSE					
CHILD					
CHILD					
CHILD					

C. Other Insurance Data (Complete when you or your dependents have other insurance coverage.)

You must report any other group insurance coverage for anyone on your insurance plan(s) **as of your effective date of retirement.** Complete the following and indicate who is covered by the policy. Attach additional pages if necessary.

NAME OF OTHER INSURANCE COVERAGE (INCLUDING MEDICARE)	POLICY HOLDER'S NAME (LAST, FIRST, MIDDLE)
POLICY #	TYPE OF COVERAGE: <input type="checkbox"/> HEALTH <input type="checkbox"/> DENTAL <input type="checkbox"/> DRUG <input type="checkbox"/> VISION
WHO IS COVERED? (CHECK ALL THAT APPLY) <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> ALL CHILDREN <input type="checkbox"/> CHILD (NAME) _____	

NAME OF OTHER INSURANCE COVERAGE (INCLUDING MEDICARE)	POLICY HOLDER'S NAME (LAST, FIRST, MIDDLE)
POLICY #	TYPE OF COVERAGE: <input type="checkbox"/> HEALTH <input type="checkbox"/> DENTAL <input type="checkbox"/> DRUG <input type="checkbox"/> VISION
WHO IS COVERED? (CHECK ALL THAT APPLY) <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> ALL CHILDREN <input type="checkbox"/> CHILD (NAME) _____	

D: Certification (Signature is required even if you are declining coverage.)

I certify that the above information is correct to the best of my knowledge and belief. If I am enrolling in insurances, by my signature below I also agree to the conditions of enrollment specified in this form's instructions.

APPLICANT'S SIGNATURE	HOME TELEPHONE NUMBER ()	DATE
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Department of Technology,
Management & Budget

Retirement Application Instructions

For Retiring State Police

Pre-Application Steps

3–6 Months Before Your Retirement Effective Date

- Review any pending service credit purchases or new purchases you plan to make. ORS must receive payment in full before you terminate to receive credit for retirement.
- Submit your completed retirement application and all required documentation and proofs to ORS.

0–3 Months Before Your Retirement Effective Date

- Notify your personnel office of your intention to retire. You must terminate all state of Michigan employment before your retirement effective date.

If you decide to cancel your application, notify ORS in writing before your retirement effective date.

The Application—Section I: Retirement Information

You have the option to apply for a full retirement or the Deferred Retirement Option Plan (DROP). Indicate the type of retirement you are applying for by checking the appropriate box.

Retirement Eligibility. You qualify for retirement at any age with 25 years of service as an enlisted officer. If you left state police prior to 25 years of service but have at least 10 years, you are eligible to collect a pension benefit at age 50.

Deferred Retirement Option Plan (DROP) Eligibility. You qualify for the DROP if you are eligible to apply for a full retirement but wish to extend your employment and defer your pension benefits for up to six years.

Eligible Domestic Relations Order. If you have an Eligible Domestic Relations Order (EDRO), which divides your pension benefit as the result of a divorce, be sure you have an acceptable copy on file with ORS.

Section II. Deferred Retirement Option Plan (DROP)

Complete this section of the application *only* if you are applying for the DROP.

DROP Participation Period. Be sure that you indicate the time frame that you will be participating in the DROP program. Your begin date is actually your *retirement effective date*.

Beneficiary Designation. Indicate who will be your beneficiary. You can name only one beneficiary. Be sure to include all pertinent information.

Upon completing this section, see Submitting Your Retirement Application section of the application or Final Steps in the instructions for where to mail.

Section III. Retirement

Complete this section and the rest of the application *only* if you are applying for a service retirement. Be sure that you indicate your *retirement effective date*, the first day of the

month following your last day on payroll with the Department of State Police, and sign your name.

Section IV. Insurance Options

Declining Insurances. If you do not wish to enroll in either the health, dental or vision insurance plans when you retire, check the “DECLINE” box(es), sign and date in Section D, then proceed to Section V. You can enroll later, but may have a six-month waiting period.

Enrolling in Insurances. The *Health, Dental, Vision, and Life Insurance Options* sheet (R0423GH) provides details about insurance eligibility. Additional information about effective dates of coverage and documents to be submitted with the retirement application to prove eligibility for enrolled dependents can be found under Continuing Your Insurance Benefits in the *Retirement Guidelines* booklet.

Coverage Options. If you are considering a Health Maintenance Organization (HMO) for your health care provider, refer to the information on the back of the *Health, Dental, Vision, and Life Insurance Options* sheet (R0423GH) for contact information. If you decide to enroll in an HMO, contact the HMO directly for an application and send your completed HMO application with this retirement application. Be sure to mark the HMO “ENROLL” box under Enrollment Options to indicate you are sending a separate application and sign the Certification section on the bottom of the insurance options page. DO NOT return your application to the HMO.



www.michigan.gov/orsmsp



P.O. Box 30171
Lansing, MI 48909-7671



(517) 322-5103 (Local)
(800) 381-5111

Retirement Application Instructions *For Retiring State Police*

Note: In 1986, federal law required mandatory Medicare coverage for state and local government employees even if they do not pay social security taxes. If you were hired (or rehired) after March 31, 1986, you may have mandatory Medicare coverage. However, the Social Security Administration is the final authority for determining your Medicare eligibility.

Coordination of Benefits. Your health, dental, and vision plans contain a *coordination of benefits (COB)* provision, which says you can't be reimbursed for more than the allowed cost of your care or service.

If you or your dependents are covered under another group plan, the plans coordinate their reimbursement so that their combined payments don't exceed the allowed costs.

Enrollment Data

Complete all requested information for each person who will be covered under your insurance plans. If anyone is enrolled in Medicare, provide that person's Medicare card number and the effective dates of coverage for both Medicare Part A and Part B. Please send ORS a copy of the Medicare card for anyone who is under age 65.

Other Insurance Data

You must report any other insurance coverage you or your

enrolled dependents have. Failure to report this coverage, including prescription drug coverage, will make you subject to loss of coverage and retroactive repayment of any claims paid by ORS.

If you enroll in one of these health insurance plans, it is your responsibility to notify ORS of any changes in your status or that of your family that may affect eligibility and/or coverage. You also authorize the administrator selected by ORS to obtain from providers of service, on a confidential basis, any records and other information relating to you and your covered dependents.

Life Insurance

Your state-sponsored life insurance continues for you and your dependents at no charge to you. Your coverage will be 25 percent of the amount of insurance you carry at the time you retire from state police employment; your dependents' policies are capped at \$1,000 each. If you are deferred, you are not eligible for life insurance.

You may want to update your beneficiary on the enclosed *Retiree Life Insurance Beneficiary Designation* form. Return your completed form with your application. Or log into miAccount at www.michigan.gov/orsmiaccount.

Section V. Income Tax Withholding Authorization

Beginning in 2012, your pension may be subject to Michigan income tax as well as federal income tax. ORS will withhold these taxes from your pension based on the information you provide. This will remain in effect until you change it through miAccount or file a new *Income Tax Withholding Authorization* form (R0012X).

If you need help determining your federal allowances or if you should withhold any additional amount, refer to IRS publication 919, available at www.irs.gov. For questions on your Michigan withholding, contact the Department of Treasury at www.michigan.gov/taxes.

Section VI. Enrolling in EFT (Direct Deposit)

You must use Electronic Funds Transfer (EFT) to deposit your monthly pension payment to your checking and/or savings account. EFT is easy and convenient. It eliminates mail delays and theft problems because no paper check is mailed. Your money is available to you the same day the pension is payable. There is no fee for the EFT service, so your monthly pension is not affected.

You must use a financial institution located in the United States or its territories. If you are living in a foreign country and do not have an account with a US financial institution, contact ORS.

You can have your EFT deposited in up to two accounts. The accounts can be at the same financial institution or

at two different institutions. Complete ALL of the financial institution information requested and indicate whether the account is checking or savings. To split your pension payment between two accounts, record the dollar amount or percentage to be deposited in the first account. The balance will go into the second account.

After retirement, you may change your EFT bank accounts through miAccount, online at www.michigan.gov/orsmiaccount. If changing bank accounts, be sure to keep your old account open until your pension payment is deposited in the new account.

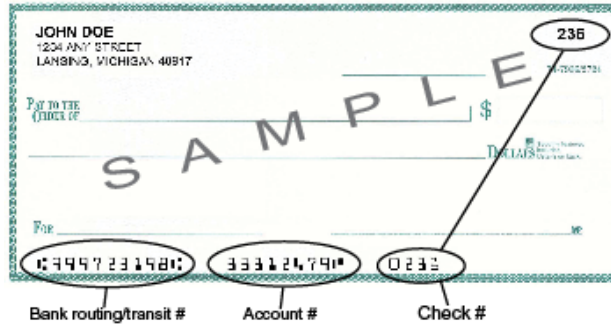
Retirement Application Instructions For Retiring State Police

Depositing to a checking account?

Looking at one of your checks, find the bank's routing number and your checking account number within the string of numbers at the bottom. (See the sample check.)

Make sure you are looking at a check and NOT a deposit slip because the numbers may not be the same.

The first 9-digit sequence from the left is your bank routing number. It is always 9 digits. If this number begins with any number other than 0, 1, 2, or 3 you will need to contact your financial institution for a different number that can be used for EFT deposits.



The other number at the bottom—the one not matching the check number—is your account number. If the number includes zeros at the beginning or end, include them as part of your account number.

Depositing to a savings account?

You may need to enclose a blank deposit slip or contact your financial institution to get the bank routing number and verify your complete savings account number. Write both of these numbers in the appropriate boxes.

Final Steps

Verify each item below. If any information is missing or incomplete your application will be returned. This could delay your first pension payment and/or your insurance effective date.

Section IV: Insurance Options

- If declining insurance at this time, the “DECLINE” box(es) are checked and you’ve signed in Section D.
- If enrolling, effective date and coverage level is indicated, plus those being covered are identified.
- If HMO is marked, an HMO application is enclosed.
- Other insurance coverage, if any, is identified.
- If enrolling, you’ve signed in Section D.

Section V: Income Tax Withholding

- Federal:** Check the box on line 1 to have no Federal income tax withheld. To withhold, check line 2, OR complete lines 3 and 4. If not completed, ORS will withhold as if married with 3 allowances.
- Michigan:** Check the box on line 5 to have no Michigan income tax withheld. To withhold, check line 6, OR complete lines 7 and 8. If not completed, ORS will withhold as if married with 3 allowances.

Section VI: Enrolling in EFT (Direct Deposit)

- Identify your account with a financial institution in the United States to receive your pension payment.

Required Documentation and Proofs

Before sending your retirement application to ORS, gather copies of all proofs and other documents to be included with your application (copies are acceptable). Write your name and Member ID or the last four digits of your social security number on each item you send so everything can be connected to your account.

Proof of Age—Required for Pension Benefit

- A copy of your birth certificate.

Insurance Proofs for Dependents, If Applicable

Provide the required documentation to verify the following: (Refer to the *Retirement Guidelines*, Continuing Your Insurance Benefits section for other documents you may submit.)

- Marriage certificate, if married
- Birth certificates to prove age and relationship
- First page of IRS 1040 to prove dependency
- Legal adoption papers
- Court orders to prove full legal guardianship
- School records as proof of attendance
- Proof of disability for incapacitated child

Return application and all documents to:

**ORS, P.O. Box 30171
Lansing, MI 48909-7671**