

I _____, hereby apply for retirement benefits from the City of San José Federated or Police/Fire Plan to become effective on _____.

The type of Retirement I am applying for is (check one):

- SERVICE DISABILITY SERVICE –CONNECTED (ALSO COMPLETE PAGE 2)
 DEFERRED VESTED DISABILITY NON-SERVICE CONNECTED (ALSO COMPLETE PAGE 2)

APPLICANT INFORMATION:

HOME ADDRESS:	SOCIAL SECURITY#:	
CITY, STATE ZIP CODE:	EMPLOYEE ID :	
HOME PHONE:	DATE OF BIRTH:	
CELL PHONE:	AGE AT RETIREMENT:	
WORK PHONE:	TOTAL YEARS OF SERVICE:	
HOME EMAIL ADDRESS:	JOB TITLE :	BARGAINING UNIT:
DEPARTMENT:	<u>DO NOT LEAVE BLANK. IF NONE THEN CHECK THE BOX, OTHERWISE PROVIDE DATE(S)</u>	
SUPERVISOR:	DATE OF DIVORCE (S) THAT OCCURRED DURING YOUR CITY SERVICE: _____	
	<input type="checkbox"/> NO DIVORCES DURING MY CITY SERVICE	

SPOUSE or CERTIFIED DOMESTIC PARTNER or NOT MARRIED

NAME:	DATE OF BIRTH:	AGE:
SOCIAL SECURITY#:	DATE OF MARRIAGE/CERTIFICATION:	

DEPENDENT INFORMATION:

(PLEASE LIST CHILDREN UNDER AGE 24. FOR CHILDREN AGE 18 OR OLDER, YOU MUST SUBMIT PROOF OF FULL TIME STUDENT STATUS)

NAME	SSN	DATE OF BIRTH	RELATIONSHIP	LEGAL DEPENDENT OF RETIREE?

RETIREE'S SIGNATURE : _____ **DATE:** _____

SPOUSE/DOMESTIC PARTNER'S SIGNATURE: _____ **DATE:** _____

FOR OFFICE USE ONLY	
ANALYST:	<input type="checkbox"/> SCD PENDING <input type="checkbox"/> CHANGE OF STATUS
AGENDA DATE: _____ AGENDA ITEM #: _____	BOARD ACTION: <input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED

RECIPROCITY:

COMPLETE THE FOLLOWING IF YOU ARE A MEMBER OF ANOTHER CALIFORNIA PUBLIC RETIREMENT SYSTEM AND YOU HAVE/ARE CLAIMING RECIPROCITY. NOTE: YOU MUST RETIRE CONCURRENTLY TO QUALIFY FOR RECIPROCAL BENEFITS.

NAME OF SYSTEM	DATES OF SERVICE CREDITED	DATE OF RETIREMENT AT RECIPROCAL SYSTEM

----- **DISABILITY RETIREMENT APPLICANTS ONLY** -----

CONSENT TO RELEASE INFORMATION

I request that the Retirement Plan make such investigation as it may deem necessary to establish the facts in my case. My personal physician, your Medical Director, and all other persons having knowledge of pertinent facts are hereby authorized to disclose them to you or to your agents for the purpose of establishing the kind and degree of my disability. I hereby also specifically consent to the release of any and all alcohol, drug abuse, or psychiatric treatment records under the same conditions as outlined above.

I understand my responsibility to the Retirement Plan in regard to engaging in a gainful occupation and the need to report all income from such occupation until I attain age 55 (Federated Retirement Plan) or until service plus retirement equal 20 years (Police and Fire Retirement Plan).

(PLEASE ATTACH ALL INDEPENDENT MEDICAL REPORTS)

MY DISABILITY /INJURED BODY PART IS:
INJURY OCCURRED ON:

ATTORNEY'S NAME REPRESENTING YOU FOR RETIREMENT*: _____

ATTORNEY ADDRESS: _____

ATTORNEY PHONE NUMBER: _____

* **DISABILITY INFORMATIONAL PACKET WILL BE SENT TO THE ATTORNEY LISTED ABOVE.**

RETIREE'S SIGNATURE (PLEASE SIGN): _____

RETIREE'S NAME (PLEASE PRINT): _____