

DEIRDRA JOYNER, Ed.D.
Superintendent

Application Process

It is recommended that you return your retirement packet and supporting documents no later than 60 days prior to your retirement effective date. Returning your information after the 60 days may delay the start of your benefits.

Please read this letter in its entirety prior to completing your packet.

Step #1A – Review, complete, and sign REQUIRED documents. Where the forms ask for “Employee ID”, you must use your Pension ID provided in the Retirement email that you received. **Print all information clearly.**

_____ Pensioner’s Bank/Credit Union Deposit Authorization

- Complete section #1 with your personal information
- Complete section #2 with your Primary banking information

_____ IRS Withholding Certificate for Periodic Pension or Annuity Payments

- Complete and return Page #1

_____ Delaware Division of Revenue Employee’s Withholding Allowance Certificate

- Complete and return Page #1

_____ Health Insurance Application or Refusal Form

- Application for “Non-Medicare” Healthcare Coverage – If you/spouse are under 65 years of age
- Application for “Medicare Supplement” Healthcare Coverage Special Medicfill – If you/spouse are 65 years of age or older

Note: *Separate applications are necessary if applicant or spouse is eligible and receiving Medicare)*

(If covering a spouse: the Spousal Coordination Form must be completed online.)

_____ Dental Insurance Application or Refusal Form

- Enter your retirement effective date at the top of the form
- Complete section “A” by selecting coverage type
 - New Enrollment **or** Termination/Refusal
- Complete section “B” by selecting coverage option/level
- Complete section “C” by selecting dental plan
- Complete section “D” with your personal information
- Complete section “E” by listing covered family members
- Sign and date the bottom of the form

_____ Vision Insurance Application or Refusal Form

- Enter your retirement effective date at the top of the form
- Complete section “A” by selecting coverage type
 - New Enrollment **or** Termination/Refusal
- Complete section “B” by selecting coverage option/level

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- Complete section “C” by selecting vision plan
- Complete section “D” with your personal information
- Complete section “E” by listing covered family members
- Sign and date the bottom of the form

____ Contributory Designation Beneficiary Form

- Complete the top section with your name and id #'s
- List at least one (1) Beneficiary
- Read the “Important Information/Terminology on 2nd Page
- Sign and date at the bottom of 2nd Page

____ Joint and Survivor Retirement Benefit Form *

- Complete the top section with your name and Pension Id #
- Place an “X” next to the amount of pension to leave your survivor
- Form **REQUIRES** notarization. Do not sign until you are in front of a notary

____ Burial Benefit Designation of Beneficiary Form *

- Complete the top section with your name and Pension Id #
- List at least one (1) Beneficiary
- Form **REQUIRES** notarization. Do not sign until you are in front of a notary

* Whiteout or scratch-outs are **NOT** acceptable on these forms. If you make a mistake, please go to <https://open.omb.delaware.gov/> and print another form.

Step #1B – Review, complete, and sign **OPTIONAL** documents

____ W-2 Change of Address Form should only be completed and returned if you are moving on or need your retirement effective date

Step #2 – Gather required documentation

- ____ Copy of Birth Certificates for you, your spouse and all dependents *(if applicable)*
- ____ Copy of Social Security Cards for you, your spouse and all dependents *(if applicable)*
- ____ Copy of Signed Medicare Card showing Part A/B for you and your spouse *(if applicable)*
- ____ Copies of Marriage Certificate(s) *(if applicable)*
- ____ Copies of Divorce Decree(s) and/or Death Certificate *(if applicable)*
- ____ Documentation of Active Military Duty (DD214) *(if applicable)*

Step #3 – Returning your completed packet and supporting documentation

There are three (3) options to return the retirement packet & supporting documentation:

1. Scan and email to CSDRetirements@Christina.k12.de.us (**Preferred Method**)
2. Interoffice mail to Christina Administrative Offices, Benefits Dept.
3. United States Postal Service (USPS) –
Christina Administrative Offices - Benefits Office
1899 S. College Ave, Newark, DE 19702
(Please note that mailing your forms can delay processing)

Note: Timely submission of the required paperwork is crucial to ensure there are no delays in receiving your monthly pension payment.

If you have any questions, please contact me at 302-552-2699.

Thank you,
Retirements Representative
Payroll & Benefits Department



STATE OF DELAWARE OFFICE OF PENSIONS

DIRECT DEPOSIT FORM

PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS

Pensioner Information (please print clearly)

Name – First, M.I., Last:

Pension ID or SSN:

☐ Check Here
for Change of
Address

Street or P.O. Box:

City:

State:

Zip Code:

Email Address:

Phone Number:

INCORRECT ROUTING AND/OR ACCOUNT NUMBERS WILL RESULT IN YOUR DIRECT DEPOSIT BEING DELAYED UNTIL THE NEXT SCHEDULED PENSION PAYMENT.

Primary Account Information

Deposit Net Monthly Pension Amount into
this account.

-or-

Use this account as primary with additional
monies going to accounts listed.

Account Type: Checking Savings
Name of Financial Institution:

Routing Number (9 Digits):

Account Number:

*** STOP and SIGN the bottom of this form if the above account is the ONLY deposit account. ***

If you wish to have specific dollar amounts deposited into additional account(s), please continue.

Continue additional deposits -or-

Stop additional deposits and deposit all monies into the above account

Additional Account(s) Information (Please List ALL Accounts)

Account Type: Checking Savings

Name of Financial Institution:

Deposit Amount: \$ _____

Routing Number (9 Digits):

Account Number:

Account Type: Checking Savings

Name of Financial Institution:

Deposit Amount: \$ _____

Routing Number (9 Digits):

Account Number:

I hereby revoke any prior deposit elections. I understand that my monthly benefit amount will be direct deposited to the account(s) designated above so that funds are available to me on the last working day of each month. I understand that I may revoke or change my deposit at any time by notifying the Office of Pensions in writing.

X _____

SIGNATURE

DATE

860 SILVER LAKE BLVD., SUITE 1 · MCARDLE BUILDING · DOVER, DE 19904 / SLC D570A
PHONE: (302) 739-4208 · TOLL FREE: (800) 722-7300 · FAX: (302) 739-6129 · EMAIL: PENSIONOFFICE@DELAWARE.GOV
WWW.DELAWAREPENSIONS.COM

DA Form Revised November 2024 - #207

Form Information

- Complete the form and return to the State of Delaware Office of Pensions by mail, fax, or Email.
- Consider maintaining accounts at both your old and new financial institution until the transaction is complete (that is, until the new financial institution receives it first benefit payment). **The change you are requesting could take up to 30 days to become effective.**
- **NOTE:** If you move and the “Pension Direct Deposit Advisory Notice” or other mailings are returned undeliverable by the Post Office, **your electronic funds transfer authorization will be suspended and the funds held** until a signed change of address has been received by the Pension Office.
- See the blank check guide below for information on where the routing and account numbers are located on your checks for assistance in completing the form. You may attach a voided check to this form as verification. **DO NOT ATTACH A DEPOSIT SLIP.**

NAME
ADDRESS
CITY, STATE ZIP

DATE

PAY TO THE
ORDER OF

\$

DOLLARS

BANK NAME
ADDRESS
CITY, STATE ZIP

FOR

0123456789 0123456789012 0123

Bank Routing Number Bank Account Number Check Number

- **THE DEPOSIT INFORMATION YOU INDICATE ON THIS FORM WILL REPLACE YOUR CURRENT DEPOSIT INFORMATION.**

**Withholding Certificate
for Periodic Pension or Annuity Payments**

Give Form W-4P to the payer of your pension or annuity payments.

2025**Step 1:
Enter
Personal
Information**

(a) First name and middle initial

Last name

(b) Social security number

Address

City or town, state, and ZIP code

(c) ☐ 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.)

TIP: Consider using the estimator at www.irs.gov/W4App to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to receive your payments only part of the year; or have changes during the year in your marital status, number of pensions/jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs or pension/annuity payments), deductions, or credits. Have your most recent payment statements/pay stubs from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See pages 2 and 3 for more information on each step, when to use the estimator at www.irs.gov/W4App, and how to elect to have no federal income tax withheld (if permitted).

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

Complete this step if you (1) have 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. **See page 2 for examples on how to complete Step 2.**

Do **only one** of the following.

(a) Use the estimator at www.irs.gov/W4App for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Complete the items below.

(i) If you (and/or your spouse) have one or more jobs, then enter the total taxable annual pay from all jobs, plus any income entered on Form W-4, Step 4(a), for the jobs less the deductions entered on Form W-4, Step 4(b), for the jobs. Otherwise, enter “-0-” . . . \$

(ii) If you (and/or your spouse) have any other pensions/annuities that pay less annually than this pension/annuity, then enter the total annual taxable payments from all lower-paying pensions/annuities. Otherwise, enter “-0-” . . . \$

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

TIP: To be accurate, submit a new Form W-4P for all other pensions/annuities if you haven't updated your withholding since 2021 or this is a new pension/annuity that pays less than the other(s). Submit a new Form W-4 for your job(s) if you have not updated your withholding since 2019.

Complete Steps 3–4(b) on this form only if (b)(i) is blank **and** this pension/annuity pays the most annually. Otherwise, do not complete Steps 3–4(b) on this form.

**Step 3:
Claim
Dependent
and Other
Credits**

If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by \$2,000 \$

Multiply the number of other dependents by \$500 . . . \$

Add other credits, such as foreign tax credit and education tax credits \$

Add the amounts for qualifying children, other dependents, and other credits and enter the total here . . . **3** \$**Step 4
(optional):
Other
Adjustments**

(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 on page 3 and enter the result here . **4(b)** \$

(c) **Extra withholding.** Enter any additional tax you want withheld from **each payment** . **4(c)** \$

Step 5:**Sign
Here****Your signature** (This form is not valid unless you sign it.)**Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about any future developments related to Form W-4P, such as legislation enacted after it was published, go to www.irs.gov/FormW4P.

Purpose of form. Complete Form W-4P to have payers withhold the correct amount of federal income tax from your periodic pension, annuity (including commercial annuities), profit-sharing and stock bonus plan, or IRA payments. Federal income tax withholding applies to the taxable part of these payments. Periodic payments are made in installments at regular intervals (for example, annually, quarterly, or monthly) over a period of more than 1 year. Don't use Form W-4P for a nonperiodic payment (note that distributions from an IRA that are payable on demand are treated as nonperiodic payments) or an eligible rollover distribution (including a lump-sum pension payment). Instead, use Form W-4R, Withholding Certificate for Nonperiodic Payments and Eligible Rollover Distributions, for these payments/distributions. For more information on withholding, see Pub. 505, Tax Withholding and Estimated Tax.

Choosing not to have income tax withheld. You can choose not to have federal income tax withheld from your payments by writing "No Withholding" on Form W-4P in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Generally, if you are a U.S. citizen or a resident alien, you are not permitted to elect not to have federal income tax withheld on payments to be delivered outside the United States and its territories.

Caution: If you have too little tax withheld, you will generally owe tax when you file your tax return and may owe a penalty unless you make timely payments of estimated tax. If too much tax is withheld, you will generally be due a refund when you file your tax return. If your tax situation changes, or you choose not to have federal income tax withheld and you now want withholding, you should submit a new Form W-4P.

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Are submitting this form after the beginning of the year;
2. Have social security, dividend, capital gain, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax;
3. Receive these payments or pension and annuity payments for only part of the year; or
4. Have changes during the year in your marital status, number of pensions/jobs for you (and/or your spouse if married filing jointly), number of dependents, or changes in your deductions or credits.

TIP: Have your most recent payment statements/pay stubs from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you (or you and your spouse) receive. If you do not have a job and want to pay these taxes through withholding from your payments, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

Payments to nonresident aliens and foreign estates. Do not use Form W-4P. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities, and Pub. 519, U.S. Tax Guide for Aliens, for more information.

Tax relief for victims of terrorist attacks. If your disability payments for injuries incurred as a direct result of a terrorist attack are not taxable, write "No Withholding" in the space below Step 4(c). See Pub. 3920, Tax Relief for Victims of Terrorist Attacks, for more details.

Specific Instructions

Submit a **separate Form W-4P** for each pension, annuity, or other periodic payments you receive.

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you have at least one of the following: income from a job, income from more than one pension/annuity, and/or a spouse (if married filing jointly) that receives income from a job/pension/annuity. The following examples will assist you in completing Step 2(b).

Example 1. Taylor, a single filer, is completing Form W-4P for a pension that pays \$50,000 a year. Taylor also has a job that pays \$25,000 a year. Taylor has no other pensions or annuities. Taylor will enter \$25,000 in Step 2(b)(i) and in Step 2(b)(iii).

If Taylor also has \$1,000 of interest income, which they entered on Form W-4, Step 4(a), then they will instead enter \$26,000 in Step 2(b)(i) and in Step 2(b)(iii). They will make no entries in Step 4(a) on this Form W-4P.

Example 2. Casey, a single filer, is completing Form W-4P for a pension that pays \$50,000 a year. Casey does not have a job, but receives another pension for \$25,000 a year (which pays less annually than the \$50,000 pension). Casey will enter \$25,000 in Step 2(b)(ii) and in Step 2(b)(iii).

If Casey also has \$1,000 of interest income, then they will enter \$1,000 in Step 4(a) of this Form W-4P.

Example 3. Sam, a single filer, is completing Form W-4P for a pension that pays \$50,000 a year. Sam does not have a job, but receives another pension for \$75,000 a year (which pays more annually than the \$50,000 pension). Sam will not enter any amounts in Step 2.

If Sam also has \$1,000 of interest income, they won't enter that amount on this Form W-4P because they entered the \$1,000 on the Form W-4P for the higher paying \$75,000 pension.

Example 4. Alex, a single filer, is completing Form W-4P for a pension that pays \$50,000 a year. Alex also has a job that pays \$25,000 a year and another pension that pays \$20,000 a year. Alex will enter \$25,000 in Step 2(b)(i), \$20,000 in Step 2(b)(ii), and \$45,000 in Step 2(b)(iii).

If Alex also has \$1,000 of interest income, which they entered on Form W-4, Step 4(a), they will instead enter \$26,000 in Step 2(b)(i), leave Step 2(b)(ii) unchanged, and enter \$46,000 in Step 2(b)(iii). They will make no entries in Step 4(a) of this Form W-4P.

If you are married filing jointly, the entries described above do not change if your spouse is the one who has the job or the other pension/annuity instead of you.



Multiple sources of pensions/annuities or jobs. If you (or if married filing jointly, you and/or your spouse) have a job(s), do NOT complete Steps 3 through 4(b) on Form W-4P. Instead, complete Steps 3 through 4(b) on the Form W-4 for the job. If you (or if married filing jointly, you and your spouse) do not have a job, complete Steps 3 through 4(b) on Form W-4P for **only** the pension/annuity that pays the most annually. Leave those steps blank for the other pensions/annuities.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible

Specific Instructions *(continued)*

in this step, such as the foreign tax credit and the education tax credits. Including these credits will increase your payments and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include amounts from any job(s) or pension/annuity payments. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your pension, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 6, if you expect to claim deductions other than

the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes itemized deductions, the additional standard deduction for those 65 and over, and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from **each payment**. Entering an amount here will reduce your payments and will either increase your refund or reduce any amount of tax that you owe.

Note: If you don't give Form W-4P to your payer, you don't provide an SSN, or the IRS notifies the payer that you gave an incorrect SSN, then the payer will withhold tax from your payments as if your filing status is single with no adjustments in Steps 2 through 4. For payments that began before 2025, your current withholding election (or your default rate) remains in effect unless you submit a new Form W-4P.

Step 4(b)—Deductions Worksheet *(Keep for your records.)*



1

Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income

1

\$

2

Enter:

• \$30,000 if you're married filing jointly or a qualifying surviving spouse

• \$22,500 if you're head of household

• \$15,000 if you're single or married filing separately

2

\$

3

If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "–0–"

3

\$

4

If line 3 equals zero, and you (or your spouse) are 65 or older, enter:

• \$2,000 if you're single or head of household.

• \$1,600 if you're married filing separately.

• \$1,600 if you're a qualifying surviving spouse or you're married filing jointly and one of you is under age 65.

• \$3,200 if you're married filing jointly and both of you are age 65 or older.

Otherwise, enter "–0–". See Pub. 505 for more information

4

\$

5

Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information

5

\$

6

Add lines 3 through 5. Enter the result here and in **Step 4(b)** on Form W-4P

6

\$

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. You are required to provide this information only if you want to (a) request federal income tax withholding from pension or annuity payments based on your filing status and adjustments; (b) request additional federal income tax withholding from your pension or annuity payments; (c) choose not to have federal income tax withheld, when permitted; or (d) change a previous Form W-4P. To do any of the aforementioned, you are required by sections 3405(e) and 6109 and their regulations to provide the information requested on this form. Failure to provide this information may result in inaccurate withholding on your payment(s). Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws. We may

also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.



STATE OF DELAWARE OFFICE OF PENSIONS

DELAWARE STATE TAX WITHHOLDING In Lieu of DE-W4

PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS

Pensioner Information

Name - First, MI, Last:		Pension ID or SSN:	
☐ Check Here for Change of Address	Street or P.O. Box:		
	City:	State:	Zip Code:
Email Address:		Phone Number:	

Choose One DELAWARE Tax Withholding Option

Taxes for any other state cannot be withheld by the Office of Pensions

- ☐ Do **not** withhold Delaware tax.
- or-
- ☐ I elect to have **only** the following amount or percent withheld each month for Delaware tax.
- Flat amount \$ _____ OR _____ %
- or-
- ☐ Calculate my monthly Delaware tax withholding using IRS tax tables and withhold that amount each month for Delaware tax.
- ☐ Married # of exemptions: _____
- ☐ Single # of exemptions: _____
- Optional:** withhold the calculated amount plus **an additional** \$ _____ per month for Delaware tax.
- or-
- ☐ Do **not** change my current Delaware tax election. (Only for existing Pensioners)

Form Information

- Generally, your benefit is taxable income. You can have Federal and/or Delaware taxes withheld from your monthly benefit.
- You are liable for the payment of taxes, interest, and penalties if your estimated tax and withholding payments are not adequate.

If you are a dual pensioner (receiving both a service and survivor pension), you **MUST** complete a separate Federal and State tax form for each benefit that you receive. Please be sure to indicate your Pension ID Number (found on your Monthly Notification of Deposit) on each form to ensure changes are applied to the proper account(s).

I hereby revoke any prior tax withholding elections. I understand that the withholding elections requested above will remain in effect until I change them. I understand that I may revoke or change my tax withholding election at any time by submitting a new Federal and Delaware State Tax Withholding form. Your request will not be processed if this form does not have a valid signature.

X _____
SIGNATURE (This form is not valid unless you sign it)

X _____
DATE

NON-MEDICARE



**STATE OF DELAWARE OFFICE OF PENSIONS
APPLICATION FOR NON-MEDICARE HEALTH CARE COVERAGE**

If refusing coverage, please complete Section A and sign the refusal at the bottom of page ONLY.

A. PERSONAL:	
Male Female Last Name:	Retiree Spouse First Name:
Pension ID OR SSN:	
Agency: OFFICE OF PENSIONS	
Date of Birth (month/day/year):	Phone Number:
Alternate Phone Number:	
Address:	
City:	State:
Zip Code:	

B. REASON FOR APPLICATION:	
Effective Date: _____	*ADD DEPENDENTS DUE TO:
New coverage	*Note: Qualifying Event Documentation Is Required
Change coverage	Marriage Adoption / Guardianship
	Non-voluntary coverage loss Other Birth

C. HEALTH CARE COVERAGE CHOICES:	
COVERAGE IS FOR:	
Individual	Individual & Spouse
Are you eligible for Double State Share? ☐ No ☐ Yes	Family

Spousal Coordination of Benefits (SCOB): If you have selected Individual & Spouse or Family Coverage, you **MUST** complete the SCOB Form upon initial enrollment, anytime enrollment or insurance status changes and each year during Open Enrollment. The SCOB Policy and electronic form can be found at <https://www.delawarepensions.com>.

D. ELIGIBLE DEPENDENTS TO BE COVERED / PRIMARY CARE PHYSICIAN SELECTION:	
*If you choose Aetna HMO coverage, you MUST include an Aetna in-network primary care physician (PCP) for yourself, spouse and all eligible dependents. If more space is needed to list dependents, please use a separate form and attach it to this application.	

Name of Your Primary Care Physician		Physician's ID Number	
Add Cancel	Spouse's Last Name	First Name	Birth Date
☐ Fulltime student Disabled	Male Female	Dependent's Last Name	Spouse's SSN
			Dependent's SSN
Add Cancel	Male Female	Dependent's Last Name	Dependent's SSN
			Dependent's SSN
Add Cancel	Male Female	Dependent's Last Name	Dependent's SSN
			Dependent's SSN

E. TERMS OF AGREEMENT:	
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I understand that: 1) Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Highmark Delaware or Aetna. 2) I certify that all representations and information supplied by me are true. My coverage shall be void if any or part of this application is false or incomplete. 3) I authorize my employer, as my agent, if applicable to collect the premiums by payroll deduction or otherwise, for remittance to Highmark Delaware or Aetna, with the understanding that payment will not be complete until actually received. 4) I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis, treatment or other health care services they render to me or my covered dependents its designee for purposes reasonably related to this contract. 5) I, on behalf of myself and my covered dependents, authorize Highmark Delaware or Aetna to release appropriate demographic information, diagnostic and medical conditions to other persons, entities or organizations for audits, claims processing, coordination of benefits, disease management programs, member satisfaction surveys, other party liability, utilization review, case management, quality improvement and assurance and other reasonably related purposes for the administration of this contract or as required by law

I <u>ELECT</u> to participate in the State Health Insurance and agree to the above terms. This is a binding election .	I <u>REFUSE</u> to participate in the State Health Insurance.
SIGNATURE	SIGNATURE
DATE	DATE

RETURN THIS FORM TO: Office of Pensions, 860 Silver Lake Blvd., Suite 1, Dover, DE 19904, FAX 302-739-6129, or Email: PENSIONOFFICE@DELAWARE.GOV.



STATE OF DELAWARE OFFICE OF PENSIONS
APPLICATION FOR HEALTH CARE COVERAGE - HIGHMARK SPECIAL MEDICFILL (Medicare Supplement)

A. PERSONAL:		Pension ID OR SSN:		Agency:	
Male	Retiree	Dependent			
Female	Spouse				
Last Name:		First Name:	Date of Birth:	Phone Number:	Alternate Phone Number:
Address:		City:	State:	Zip Code:	

B. REASON FOR APPLICATION:	Termination/Refusal of coverage for spouse and/or dependents *You must complete section A and sign below.
New coverage	
Change coverage	
Information change	Double State Share Eligible
Effective Date of Coverage: _____	

C. HEALTH CARE COVERAGE CHOICES:	MEDICARE INFORMATION: Must enroll if eligible <i>Please include copy of Medicare card with this application.</i>
MEDICARE SUPPLEMENT COVERAGE CHOICE:	Medicare #: _____
Highmark Special Medicfill with prescription	Part A Effective Date: _____ Part B Effective Date: _____
Highmark Special Medicfill without prescription	

D. OTHER COVERAGE INFORMATION:		Name of Other Insurance Company:
Are you covered by other health insurance?	Are you covered by another Part D qualified prescription plan?	
Y N	Y N	

E. TERMS OF AGREEMENT:
I understand that: 1) Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Highmark Delaware. 2) I certify that all representations and information supplied by me are true. My coverage shall be void if any or part of this application is false or incomplete. 3) I authorize my employer, as my agent, if applicable to collect the premiums by payroll deduction or otherwise, for remittance to Highmark Delaware with the understanding that payment will not be complete until actually received. 4) I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis treatment or other health care services they render to me or my covered dependents its designee for purposes reasonably related to this contract. 5) I, on behalf of myself and my covered dependents, authorize Highmark Delaware to release appropriate demographic information, diagnostic and medical conditions to other persons, entities or organizations for audits, claims processing, coordination of benefits, disease management programs, member satisfaction surveys, other party liability, utilization review, case management, quality improvement and assurance and other reasonably related purposes for the administration of this contract or as required by law.

I ELECT to participate in the State Health Insurance and agree to the above terms. This is a **binding election**.

X	X	DATE
SIGNATURE		

For Retiree and/or Spouse age 65 or older



STATE OF DELAWARE
OFFICE OF PENSIONS

DENTAL APPLICATION
OR REFUSAL

PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS

Effective Date: _____

A. PLEASE CHECK THE APPLICABLE BOX OR BOXES:

New Enrollment	Termination/Refusal	Change of Dependents
Coverage Change	Address Change	☐ Name Change

B. PLEASE SELECT COVERAGE OPTION:

Individual	Individual & Child(ren)
Individual & Spouse	Family

C. PLEASE SELECT ONE DENTAL PLAN:

Delta Dental	
Dominion National *Must provide Dentist Name	

D. PLEASE COMPLETE ALL PERSONAL INFORMATION:

Pension ID or SSN:	Name (Last):	Name (First):	Date of Birth:
Address:			Home Phone Number:
City:	State:	Zip Code:	Work Phone Number:

E. PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:

Last Name	First Name	Date of Birth	Social Security Number	* Primary Care Dentist Name or Code
Self				
Spouse				
Child fulltime student disabled				
Child fulltime student disabled				
Child fulltime student disabled				

The dental plan is a **binding election**. Once enrolled, you may not drop coverage during the plan year unless you experience a qualifying event. **Please note:** *The enrollment form is for the Pension Office's use only and will not be used for any external purpose.*

X _____
SIGNATURE

X _____
DATE



STATE OF DELAWARE
OFFICE OF PENSIONS

VISION APPLICATION
OR REFUSAL

PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS

Effective Date: _____

A. PLEASE CHECK THE APPLICABLE BOX OR BOXES:

New Enrollment	Termination/Refusal	Change of Dependents
Coverage Change	Address Change	Name Change

B. PLEASE SELECT THE COVERAGE OPTION:

Individual	Individual & Child(ren)
Individual & Spouse	Family

C. PLEASE SELECT ONE VISION PLAN:

High
Low

D. PLEASE COMPLETE ALL PERSONAL INFORMATION:

Pension ID or SSN:	Name (Last, First, Middle Initial):	Date of Birth:
Home Address:		Home Phone:
City:	State:	Zip Code:
		Work Phone:

E. PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:

Last Name	First Name	Date of Birth	SSN
Self			
Spouse			
Child fulltime student disabled			
Child fulltime student disabled			
Child fulltime student disabled			

X _____
SIGNATURE DATE

The vision plan is a **binding election**. Once enrolled, you may not drop coverage during the plan year unless you experience a qualifying event. **Please note: The enrollment form is for the Pension Office's use only and will not be used for any external purpose.**



STATE OF DELAWARE
OFFICE OF PENSIONS

DESIGNATE OR CHANGE
BENEFICIARY FOR PENSION
CONTRIBUTIONS

PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS

Name (Print): _____ Pension ID, Employee ID or SSN: _____

Please complete form in its entirety and return to the Pension Office. Incomplete forms may be rejected.

PENSION PLAN (Check One):

State Employees' State Police Judiciary Legislators'
C/M Police/Fire C/M General (Vol) Fire Port

I hereby **revoke any previous beneficiary(ies) designation** of my pension contributions. I direct that any excess amount of my accumulated pension contributions, with interest, be paid to the living beneficiary(ies) as designated. When completing this form, **at least one Primary beneficiary** must be designated. If more than one beneficiary is designated, unless primary and secondary is noted, I understand payment will be made in equal shares, unless otherwise specified. If no designated or living beneficiary, for all or any part of the death benefit, the death benefit will be payable to my estate. (See page 2 for additional information.)

Primary	Gender:	M	F
Full Name of Individual, Funeral Home or Organization: _____			
Date of Birth: _____ SSN / EIN: _____ Relationship: _____			
Mailing Address: _____			
Optional Contact Information (Telephone/Email): _____ / _____			
Primary	Secondary	(Choose one – Secondary receives money if Primary deceased)	
Gender:	M	F	
Full Name of Individual, Funeral Home or Organization: _____			
Date of Birth: _____ SSN / EIN: _____ Relationship: _____			
Mailing Address: _____			
Optional Contact Information (Telephone/Email): _____ / _____			
Primary	Secondary	(Choose one – Secondary receives money if Primary deceased)	
Gender:	M	F	
Full Name of Individual, Funeral Home or Organization: _____			
Date of Birth: _____ SSN / EIN: _____ Relationship: _____			
Mailing Address: _____			
Optional Contact Information (Telephone/Email): _____ / _____			
Primary	Secondary	(Choose one – Secondary receives money if Primary deceased)	
Gender:	M	F	
Full Name of Individual, Funeral Home or Organization: _____			
Date of Birth: _____ SSN / EIN: _____ Relationship: _____			
Mailing Address: _____			
Optional Contact Information (Telephone/Email): _____ / _____			

COMPLETE AND SIGN ON PAGE 2



Primary	Secondary	(Choose one – Secondary receives money if Primary deceased)	Gender:	M	F
Full Name of Individual, Funeral Home or Organization: _____					
Date of Birth: _____ SSN / EIN: _____ Relationship: _____					
Mailing Address: _____					
Optional Contact Information (Telephone/Email): _____ / _____					

Primary	Secondary	(Choose one – Secondary receives money if Primary deceased)	Gender:	M	F
Full Name of Individual, Funeral Home or Organization: _____					
Date of Birth: _____ SSN / EIN: _____ Relationship: _____					
Mailing Address: _____					
Optional Contact Information (Telephone/Email): _____ / _____					

By signature below, I hereby **revoke any previous beneficiary(ies) designation** of my pension contributions.

X _____

SIGNATURE
DATE

Important Information/Terminology
• To be accepted, this form must include: ○ A primary beneficiary, either a person, funeral home, organization or your estate ○ Complete information for each beneficiary including SSN/EIN for each beneficiary ○ Signature and Date • Unpaid Pension Contributions: Amount of the unpaid pension contributions plus interest through date of death if no eligible survivor entitled to receive a survivor pension under my Plan. • Priority of eligible survivors can be found on the Office of Pensions website under Retirees/State Employee Pension Benefits/Survivor Benefits. • EIN: Employer Identification Number, also known as the Federal Tax Identification Number, is a number assigned by the IRS to business entities/charities. You will need the EIN if you are designating a charity, for example, to receive your contributions.



STATE OF DELAWARE
OFFICE OF PENSIONS

JOINT AND SURVIVOR
BENEFIT FORM

PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS

Name: _____ Pension ID: _____
(PLEASE PRINT)

In accordance with 11 Del. C. § 8368, 11 Del. C. § 8821(a), 29 Del. C. § 5527(g)(1), 29 Del. C. § 5577, and 29 Del. C. § 5613(3), the employee **must** complete this form prior to the issuance of the first pension check even if you do not have an eligible survivor. Once this election has been made, it shall be **IRREVOCABLE and cannot be changed for any reason including any future change in the pensioner's survivor, marital, or dependent status.**

The purpose of this form is for you to choose the percentage of the monthly pension that you would like to leave to your eligible survivor(s) at the time of your death (an eligible survivor is your spouse, dependent children under 18, children 18 to 22 that are full time students, a child that is permanently disabled as a result of a disability which began before the child attained age 18, or your dependent parents).

I elect a survivor's monthly pension equal to 50% of the service or disability pension benefit that I will be receiving at the time of my death. This is an option that could be chosen if you have no eligible survivors and expect to have no eligible survivors in the future. Under this election, my service or disability pension will not be reduced.

I elect to reduce my service or disability pension by 2% to provide a survivor's monthly pension equal to 66.67% of the reduced service or disability pension that I will be receiving at the time of my death.

I elect to reduce my service or disability pension by 3% to provide a survivor's monthly pension equal to 75% of the reduced service or disability pension that I will be receiving at the time of my death.

I elect to reduce my service or disability pension by 6% to provide a survivor's monthly pension equal to 100% of the reduced service or disability pension that I will be receiving at the time of my death.

**Your signature on this form must be notarized.
Do not sign this form until you are in the presence of the notary public.**

X _____
SIGNATURE

TELEPHONE NUMBER

For Use by Notary Public Only

Sworn to and subscribed before me this _____ day of

_____, 20_____.

Signature of Notary Public

Place Notary Stamp Here

State Employees' Pension Plan - Death Benefits

If you die leaving no eligible survivors, your beneficiary will be paid a lump sum equal to the excess, if any, of your accumulated contributions with interest less all pension payments made, including survivor's benefits. You may designate a beneficiary by completing an [Contributory Designation / Change of Beneficiary \(BEN-1\) form](#). If there is no designated beneficiary, the sum will be paid to your estate.



At the beginning of your retirement, you will be / were asked to complete a [Burial Benefit Designation/Change of Beneficiary form](#) to designate a beneficiary to receive a burial benefit payment of \$7,000. This is not a life insurance policy. It has no policy number and no cash value during your lifetime. This sum will be payable to the designated beneficiary upon your death.

Please be aware that that this is a taxable benefit to whomever you name as beneficiary.

The beneficiary will have the right to take the monies in several different ways. The beneficiary may choose to take the monies as a cash payment or to assign the monies to a funeral home. Both of these options create a taxable event for the beneficiary. The beneficiary will receive tax form 1099R and be required to claim the monies on their income tax return as taxable income. The beneficiary has the option to avoid a taxable event by rolling monies over to an IRA or other eligible plan. If a spouse is the named beneficiary, the monies can be rolled into a traditional IRA or any other plan that will accept them. If anyone other than a spouse is named beneficiary, they are limited to rolling the monies only to an Inherited (or Beneficiary) IRA.

If you have named a beneficiary only so that person can use the burial benefit monies to pay funeral expenses, please be aware the release of these monies will create a taxable event for that person.

If it is your intention for the burial benefit to be used to pay for your funeral expenses, you have the option to name the funeral home as the beneficiary.

In order to do this, you must contact the funeral home to get their Tax Identification Number so you can complete the Designation of Beneficiary form in its entirety. If you choose this option, the Pension Office will, after being notified of your death, release all burial benefit paperwork to the funeral home, the funeral home will complete the paperwork, and then payment will be released directly to the funeral home. In this way, no taxable event is created for a relative or friend who is doing nothing more than completing paperwork and assigning the monies to a funeral home.

Regardless of who you name as beneficiary, you should always make sure the Pension Office has up-to-date contact information for that individual or individuals. Payment cannot be made if we are unable to contact your beneficiary to provide them with the necessary paperwork to be completed and/or request appropriate documentation.

Post Retirement Burial Benefit

Please read prior to designating a beneficiary!

Please be aware that this is a taxable benefit to the beneficiary.

If you are naming an individual as beneficiary for the sole purpose of paying funeral expenses, please be aware the release of these monies will create a taxable event for that person.

The beneficiary will receive a tax form 1099-R and be required to report the monies on their personal income tax return as taxable income.

If you intend for the burial benefit to pay your funeral expenses, you have the option to name the funeral home as the beneficiary. The funeral home will receive the payout and assume the tax liability for the monies.

To assign a funeral home as beneficiary, you must contact the funeral home and obtain their Tax Identification Number to complete the Designation of Beneficiary form in its entirety. If you choose this option, the Pension Office will, after being notified of your death, release all burial benefit paperwork to the funeral home. The funeral home will complete the paperwork, and payment will be released directly to the funeral home. The Pension Office sends the 1099-R to the funeral home and no individual will be responsible for reporting the taxable income.

Also, be aware your form must be



to be valid!



STATE OF DELAWARE
OFFICE OF PENSIONS

BURIAL BENEFIT
DESIGNATION FORM

PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS

Name (Print): _____ Member ID or SSN: _____

Please complete form in its entirety and return to Pension Office. Incomplete forms will be rejected.

State Employees'
(Retiree Only)

New State Police
(Retiree Only)

Closed State Police
(Retiree Only)

Legislators'
(Retiree Only)

County and Municipal Police
and Firefighters'
(Only applies to members
actively employed upon death)

Primary

Gender: M F

Full Name of Individual, Funeral Home or Organization: _____

Date of Birth: _____ SSN / EIN: _____ Relationship: _____

Mailing Address: _____

Optional Contact Information (Telephone/Email): _____ / _____

Primary

Secondary

(Choose one – Secondary receives money if Primary deceased)

Gender: M F

Full Name of Individual, Funeral Home or Organization: _____

Date of Birth: _____ SSN / EIN: _____ Relationship: _____

Mailing Address: _____

Optional Contact Information (Telephone/Email): _____ / _____

Primary

Secondary

(Choose one – Secondary receives money if Primary deceased)

Gender: M F

Full Name of Individual, Funeral Home or Organization: _____

Date of Birth: _____ SSN / EIN: _____ Relationship: _____

Mailing Address: _____

Optional Contact Information (Telephone/Email): _____ / _____

I hereby direct that any amount of burial benefit payable at my death be paid to the Beneficiary(ies) designated above, if living. I understand that if more than one Beneficiary is designated, payment will be made in equal shares to each of the designated Beneficiary(ies) as survive me, unless otherwise specified herein. If, at my death, there is no appropriately designated Beneficiary(ies), for all or any part of the death benefit, the burial benefit may be payable to my estate. Following my death, the burial benefit will be paid after my Beneficiary(ies) have completed and submitted the necessary documentation to the Office of Pensions. The burial benefit is subject to federal income tax.

THIS FORM REVOKES ALL PREVIOUS BENEFICIARY DESIGNATIONS.

All beneficiaries must be restated even if they are not being changed. For example, if you are changing only the secondary beneficiary, you must also restate the primary beneficiary.

X _____
SIGNATURE

TELEPHONE NUMBER

For Use by Notary Public Only

Sworn to and subscribed before me this _____ day of

_____, 20____.

Signature of Notary Public

Place Notary Stamp Here



STATE OF DELAWARE OFFICE OF PENSIONS

CHANGE OF ADDRESS FORM

PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS

Please submit a Change of Address Form for any change in your mailing address (whether permanent or temporary). We cannot accept address change requests over the telephone. **Even if you receive your allowance through direct deposit, the Office periodically mails important documents, such as 1099-R Tax Forms and Benefits Open Enrollment.** If you have a temporary residence for a few months each year (e.g. winter house in Florida), please provide the date you will be at each address.

Name: First, M.I., Last (please print):

Date for Change:

Email Address:

Pension ID or SSN:

OLD ADDRESS

Street or P.O. Box

Phone Number

City/Town

State

Zip Code (5 digit Zip Code only)

Country (If outside of the U.S.)

NEW ADDRESS

Street or P.O. Box

Phone Number

City/Town

State

Zip Code (5 digit Zip Code only)

Country (If outside of the U.S.)

PLEASE RECORD MY NEW
ADDRESS AS A (CHECK ONE):

PERMANENT CHANGE

TEMPORARY CHANGE*

***If TEMPORARY, please complete the following:**

I wish to receive mail at this address beginning on _____ and ending on _____.
Start Date End Date

X _____
SIGNATURE

DATE

Please check if:

POWER OF ATTORNEY

GUARDIAN

This form may be signed by a Power of Attorney or Guardian as long as a copy of the legal document is on file with the Office of Pensions.