CHRISTINA SCHOOL DISTRICT
Together, Educating Every Student for Excellence

CHRISTINA SCHOOL DISTRICT
Drew Educational Support Center
1899 S. College Ave
Newark, Delaware 19702

Payroll and Benefits
Phone: (302) 552-2640
TDD: (800) 232-5470

DAN SHELTON, ED.D.
Superintendent

ROBERT VACCA
Supervisor, Payroll & Benefits

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 #1 – 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 *(**MUST** complete one or the other)*
- 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 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 #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 Tirzha.Brown@Christina.k12.de.us (***Preferred Method***)
2. Interoffice mail to Christina School District at Glasgow High, Tirzha Brown - Benefits
3. United States Postal Service (USPS) –
   Christina School District - 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 302-552-2640.

Thank you,
Tirzha Brown, Program Assistant
Payroll & Benefits Department

RESET FORM

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.

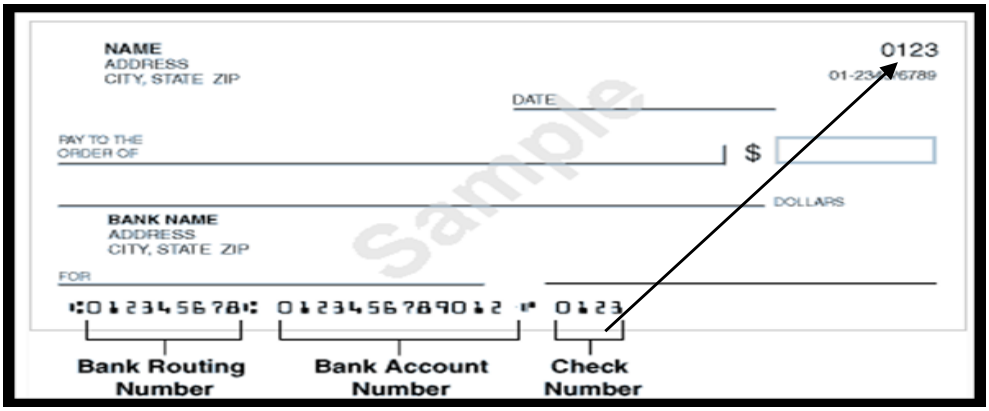
X_____ _____

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

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**.



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

Form **W-4P**
(Rev. January 2022)
Department of the Treasury
Internal Revenue Service

Withholding Certificate for Periodic Pension or Annuity Payments

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

OMB No. 1545-0074

2022

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 widow(er)**
☐ **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; otherwise, skip to Step 5. See pages 2 and 3 for more information on each step 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) Reserved for future use.

(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 one, 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 2022 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. If you have self-employment income, see page 2.

If (b)(i) is blank and this pension/annuity pays the most annually, complete Steps 3–4(b) on this form.
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.

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 1a, 1b, 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 possessions.

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 chose not to have federal income tax withheld and you now want withholding, you should submit a new Form W-4P.

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, you should enter the self-employment income in Step 4(a). Then compute your self-employment tax, divide that tax by the number of payments remaining in the year, and include that resulting amount per payment in Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if your self-employment income multiplied by 0.9235 is over $147,000.

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

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.

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

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

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

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

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

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

Example 4. Ann, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Ann also has a job that pays $25,000 a year and another pension that pays $20,000 a year. Ann 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 Ann also has $1,000 of interest income, which she entered on Form W-4, Step 4(a), she 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). She 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.

CAUTION ***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 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.

Specific Instructions *(continued)*

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 2022 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 2022, 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 2022 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: • $25,900 if you're married filing jointly or qualifying widow(er) • $19,400 if you're head of household • $12,950 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: • $1,750 if you're single or head of household. • $1,400 if you're a qualifying widow(er) or you're married and one of you is under age 65. • $2,800 if you're married 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 possessions 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.

DELAWARE
DIVISION OF REVENUE

FORM W-4

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1 FIRST NAME AND MIDDLE INITIAL	LAST NAME	2 TAXPAYER ID
HOME ADDRESS (Number and street or rural route)		3 MARITAL STATUS
		☐ Single ☐ Married
CITY OR TOWN	STATE	ZIP CODE

4	Total number of dependents you can claim on your return	4
5	Additional amount, if any, you want withheld from each paycheck	5 $

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless signed) ▶ _____ **Date** ▶ _____

6 Employer's name and address (**Employer:** Complete boxes 6 through 8 if sending to the Delaware Division of Revenue and the State Directory of New Hires.)	7 First date of employment	8 Employer identification number (EIN)

DELAWARE
DIVISION OF REVENUE

FORM W-4R

RESIDENT WITHHOLDING ALLOWANCE(S) COMPUTATION WORKSHEET

Use the following instructions to determine the correct number of allowances for withholding.
Include only those individuals that you would include on your final income tax return.

A	Enter "1" for Yourself (2 if 60 years old or older) if no one else claims you as a dependent	A	
B	Enter "1" for your Spouse (2 if 60 years old or older) if no one else claims your spouse as a dependent	B	
C	Enter number of dependents other than your spouse that you will claim	C	
D	Enter "1" if you qualify to take a child/dependent care *credit* for one child or dependent and "2" if you qualify to take the credit for two or more	D	
E	Enter "1" for you are 65 or over OR blind. Enter "2" if you are both 65 or over AND blind.	E	
F	Enter "1" if your spouse is 65 or older OR blind. Enter "2" if your spouse is 65 or older AND blind.	F	
G	**Add** Line A through Line F	G	

If you plan to itemize, or you receive non-wage income, or you can claim other deductions and wish to adjust your withholding, continue with the following Section H. Otherwise, **STOP HERE** and enter the number from Line G onto the Delaware Form W-4**.**

H	DEDUCTIONS AND INCOME ADJUSTMENTS

NOTE: Use this section only if you plan to itemize, claim other deductions, or have nonwage income. If computing this section on **Married Filing Separate** or **Combined Separate** status, include only the amount of itemized deductions that may be claimed on your separate return.

1	Enter an estimate of your itemized deductions for the current year, i.e. home mortgage interest, real estate and other taxes (excluding state income tax paid) limited to $10,000, charitable contributions, medical expenses in excess of 10% of adjusted gross income, and miscellaneous deductions (most miscellaneous deductions are now deductible only in excess of 2% of your adjusted gross income).	1	$
2	Delaware Standard Deduction of $3,250	2	$ 3,250.00
3	**Subtract** Line 2 from Line 1. If less than zero, enter 0.	3	$
4	Enter an estimate of your adjustments to income for the current year incuding alimony paid, IRA contributions, the pension exclusion and the exclusion for certain persons over 60 years old or disabled	4	$
5	**Add** Lines 3 and 4	5	$
6	Enter an estimate of your non-wage income for the current year	6	$
7	**Subtract** Line 6 from Line 5	7	$
8	**Divide** the amount on Line 7 by $2,000. Round down to nearest whole number.	8	
9	Enter the number from Line G above	9	
10	**Add** Lines 8 and 9. Report this number of allowances to your employer on Delaware Form W-4.	10	

H	SPECIAL INSTRUCTIONS

If the total on Line 10 is less than zero you may need additional withholding as a result of non-wage income to avoid owing tax on your income tax return. You can calculate the amount of additional withholding as follows:

(1) Multiply number on Line 10 by $110;
(2) Divide the result by the number of pay periods during the year (e.g., if you are paid monthly, divide by 12); The result is the additional amount of withholding required per pay.

EXAMPLE: Total on Line 10 is "-2" and you are paid once a month.
(1) Line H = 2 x $110 = $220.00
(2) Number of pay periods = $220.00/12 = $18.33

You should notify your employer on a Delaware Form W-4 that your withholding allowance should be "0" and an additional $18.33 per pay should be withheld for the current year.

DELAWARE
DIVISION OF REVENUE

FORM W-4NR

NON- RESIDENT WITHHOLDING ALLOWANCE(S) COMPUTATION WORKSHEET

A	Enter “1” for Yourself (2 if 60 years old or older) if no one else claims you as a dependent	**A**	
B	Enter “1” for your Spouse (2 if 60 years old or older) if you claim your spouse as a dependent on the State tax return	**B**	
C	Enter number of dependents other than your spouse that you will claim	**C**	
D	**Add** Lines A through C	**D**	

INCOME AND ADJUSTMENTS

			Column A TOTAL	Column B DELAWARE SOURCE
1	Wages	**1**		
2	Non-wage Income (Net of Losses - See Instructions)	**2**		
3	Total Income (**Add** Line 1 and Line 2)	**3**		
4a	Federal Adjustments to Income (See Instructions)	**4a**		
4b	Delaware Adjustments to Income (See Instructions)	**4b**		
4c	Total Adjustments to Income (**Add** Line 4a and Line 4b)	**4c**		
5	Adjusted Gross Income (**Subtract** Line 4c from Line 3)	**5**		
6	**PRORATION DECIMAL** (Line 5: Column B ÷ Column A)	**6**		

DEDUCTIONS

7	Deductions (Higher of Standard or Itemized - See Instructions)	**7**	
8	Estimated Taxable Income (**Subtract** Line 7 from Line 5, Column A)	**8**	
9	Gross Tax Liability (Computed using Line 8 - See Example Below)	**9**	
10	Personal Credits (**Multiply** Line D by $110)	**10**	
11	Net Liability before Proration (**Subtract** Line 10 from Line 9)	**11**	
12	Proration Decimal (Enter from Line 6)	**12**	
13	Estimated Tax Liability (**Multiply** Line 11 by Line 12)	**13**	
14	Number of Pay Periods (From Employer or See Instructions)	**14**	
15	Withholding per Pay Period (**Divide** Line 13 by Line 14)	**15**	

TAX TABLE

Taxable Income Between			Pay	Plus	On Amounts Over
$ 0	-	2,000	$ 0.00	0.00 %	$ 0
2,001	-	5,001	$ 0.00	2.20 %	$ 2,000
5,001	-	10,001	$ 66.00	3.90 %	$ 5,000
10,001	-	20,001	$ 261.00	4.80 %	$ 10,000
20,001	-	25,001	$ 741.00	5.20 %	$ 20,000
25,001	-	60,001	$ 1,001.00	5.55 %	$ 25,000
60,001	&	over	$ 2,943.50	6.60 %	$ 60,000

EXAMPLE OF GROSS TAX LIABILITY CALCULATION:

If you Estimated Taxable Income, (Line 8) is $12,000:

PAY: $261.00 + {(12,000 - 10,000) x 0.048}
= $261.00 + (2,000 x 0.048)
= $261.00 + 96.00
= $357.00

NON-MEDICARE

RESET FORM

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.

For Retiree and/or Spouse under age 65

A.PERSONAL:

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

B. REASON FOR APPLICATION:

Effective Date: _____

☐ New coverage
☐ Change coverage

***ADD DEPENDENTS DUE TO:**
****Note: Qualifying Event Documentation Is Required***
☐ Marriage ☐ Adoption / Guardianship
☐ Non-voluntary coverage loss ☐ Other ☐ Birth

***CANCEL DEPENDENTS DUE TO:**
☐ Divorce ☐ Over age ☐ No longer dependent
☐ Death ☐ Other

C. HEALTH CARE COVERAGE CHOICES:

COVERAGE IS FOR:
☐ Individual ☐ Individual & Spouse ☐ Individual & Child(ren) ☐ Family
Are you eligible for Double State Share? ☐ No ☐ Yes

PLEASE MAKE ONE HEALTHCARE COVERAGE CHOICE:
☐ Highmark Delaware First State Basic Plan ☐ Aetna HMO Plan
☐ Highmark Delaware Comprehensive PPO Plan ☐ Aetna Consumer Directed Health Gold Plan

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

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

X_____ X_____
SIGNATURE **DATE**

I **REFUSE** to participate in the State Health Insurance.

X_____ X_____
SIGNATURE **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.

RESET FORM

STATE OF DELAWARE OFFICE OF PENSIONS

APPLICATION FOR HEALTH CARE COVERAGE - HIGHMARK SPECIAL MEDICFILL (Medicare Supplement)

For Retiree and/or Spouse age 65 or older

A. PERSONAL:

☐ Male ☐ Female	☐ Retiree ☐ Spouse ☐ Dependent	Pension ID OR SSN:	Agency: **OFFICE OF PENSIONS**

Last Name:	First Name:	Date of Birth:	Phone Number:	Alternate Phone Number:

Address:	City:	State:	Zip Code:

B. REASON FOR APPLICATION:

☐ New coverage
☐ Change coverage
☐ Information change
☐ Termination/Refusal of coverage for spouse and/or dependents
***You must complete section A and sign below.**
☐ Double State Share Eligible

Effective Date of Coverage: _____

C. HEALTH CARE COVERAGE CHOICES:

MEDICARE SUPPLEMENT COVERAGE CHOICE:

☐ Highmark Special Medicfill with prescription

☐ Highmark Special Medicfill **without** prescription

MEDICARE INFORMATION: Must enroll if eligible

Please include copy of Medicare card with this application.

Medicare #: _____

Part A Effective Date:_____ Part B Effective Date:_____

D. OTHER COVERAGE INFORMATION:

Are you covered by other health insurance?	If YES, is this coverage an Advantage Plan?	Are you covered by another Part D qualified prescription plan?	Name of Other Insurance Company:
☐ Y ☐ N	☐ 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_____

SIGNATURE **DATE**

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

RESET FORM

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_____ X_____

SIGNATURE **DATE**

860 SILVER LAKE BLVD., SUITE 1 · MCARDLE BUILDING · DOVER, DE 19904 / SLC D570A
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WWW.DELAWAREPENSIONS.COM

RESET FORM

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.***

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RESET FORM

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.**

RESET FORM

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

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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!

RESET FORM

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

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CHRISTINA SCHOOL DISTRICT

DISTRICT FORMS

The next set of forms are District Forms and completion is **optional**.

1. Delaware Retired School Personnel Association is an organization devoted to improving the lives of Delaware public school retirees. Information for DRSPA can be found on their website at http://www.drspa.org/.

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

CHRISTINA SCHOOL DISTRICT
Together, Educating Every Student for Excellence

CHRISTINA SCHOOL DISTRICT
Drew Educational Support Center
600 North Lombard Street
Wilmington, Delaware 19801

Payroll and Benefits
Phone: (302) 552-2640
Fax: (302) 552-2699
TDD: (800) 232-5470

DAN SHELTON, ED.D.
Superintendent

ROBERT VACCA
Supervisor, Payroll & Benefits

DELAWARE RETIRED SCHOOL PERSONNEL ASSOCIATION (DRSPA) AUTHORIZATION AND RELEASE

The Delaware Retired School Personnel Association (DRSPA) is an organization devoted to improving the lives of Delaware public school retirees. At this time DRSPA efforts are focused on three important issues: protecting the pension plan, seeking pension adjustments to offset the effects of inflation, and maintaining much needed medical benefits.

Information regarding the Delaware Retired School Personnel Association (DRSPA) can be found at http://www.drspa.org/. If you need additional information you can email them at Email@drspa.org.

If you would like to be contacted by DRSPA, please provide your information below:

Print Name: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Personal Email: _____

By signing below, I authorize the Christina School District to release my address to the **Delaware Retired School Personnel Association** my information and records related to my financial information, pension, benefits, and other employment information.

Signature: _____ Date: _____

RESET FORM

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 _____ (Start Date) and ending on _____ (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.

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WWW.DELAWAREPENSIONS.COM

COA Form Revised April 2021 - **#205**