

DEATH BENEFIT APPLICATION

DERP ID: _____

I, _____, the designated beneficiary of _____, who was a deceased member of the Denver Employees Retirement Plan and an employee, or former employee, of the City and County of Denver, or other covered employer, hereby make application for death benefits as provided for in Sections 18-401 through 18-433 of the Revised Municipal Code of the City and County of Denver.

The member died on _____, and I hereby submit an **original, certified** death certificate.

Beneficiary Name: _____
First Name, Middle Initial, Last Name

Date of Birth: _____ **Gender:** M / F **Social Security Number:** _____

Effective Date of Benefit: _____ **Benefit Type:** _____

Residence Address: _____
Address, City, State, Zip Code

Mailing Address: _____
☐ **Same as Residence** *Address, City, State, Zip Code*

Primary Phone Number: _____ **Cell Phone Number:** _____

Email Address: _____

- ☐ I am the spouse of the deceased member and I understand that the monthly benefit terminates upon my death. (Applicable for both Active Death and Joint and Survivor Benefits)
- ☐ I am the designated beneficiary of the deceased member and I understand that the monthly benefit terminates upon my death. (Applicable for both Active Death and Joint and Survivor Benefits)
- ☐ I am the child of the deceased member and am under 21 years old. I understand that the monthly benefit will terminate at the end of the month I reach age 21. (Applicable for Active Death Benefit only)

BENEFICIARY DESIGNATION

I hereby designate _____ as my beneficiary for any outstanding monies due to me upon my death.

Social Security Number: _____ **Gender:** M / F **Date of Birth:** _____

Address: _____ **Phone number:** _____
Address, City, State, Zip Code

DERP ID: _____

DIRECT DEPOSIT INFORMATION

Per Section 18-413(b)(2) of the DRMC, you must receive your retirement benefit by direct deposit to your bank account. Please attach a voided check or letter from the banking institution indicating correct routing and account numbers.

John Doe 123 Street Anywhere, USA	Date: _____	XXXX
Pay to the order of: _____	EXAMPLE	\$ _____
Bank Name _____		
Memo: _____		--- VOID ---
(Nine-Digit Routing Number)		(Account Number)

By signing this application, I authorize the Denver Employees Retirement Plan (DERP) to automatically deposit my payments to my account as indicated. I further authorize DERP, if necessary, to make adjustments to the account indicated to correct any credit or debit entries made in error. I understand that DERP will make a reasonable effort to notify me when an adjustment is made.

INCOME TAX WITHHOLDING ELECTION

The monthly benefit you receive from DERP is subject to federal tax withholding according to federal tax guidelines. Currently, Colorado law excludes from state taxation pension income up to \$24,000 per year for those age 65 and over, and \$20,000 per year for those age 55 to 64. DERP is unable to withhold taxes for any state other than Colorado. Please indicate below how you would like taxes withheld from your DERP benefit. Please note that DERP staff is unable to provide tax counseling. You should seek legal and tax advice before completing this section.

FEDERAL TAX WITHHOLDING ELECTION

<input type="checkbox"/>	Do not withhold federal income tax.
<input type="checkbox"/>	Withhold federal income tax based on the tax tables for: <input type="checkbox"/> A married individual [plus \$ _____ optional] <input type="checkbox"/> A single individual [plus \$ _____ optional]
<input type="checkbox"/>	Withhold federal income tax based on either a fixed amount or percentage: <input type="checkbox"/> I elect to have \$ _____ withheld from each benefit payment <input type="checkbox"/> I elect to have _____ % withheld from each benefit payment

COLORADO STATE TAX WITHHOLDING ELECTION

<input type="checkbox"/>	Do not withhold Colorado state tax.
<input type="checkbox"/>	Withhold Colorado state tax based on the tax tables for: <input type="checkbox"/> A married individual [plus \$ _____ optional] <input type="checkbox"/> A single individual [plus \$ _____ optional]
<input type="checkbox"/>	Withhold Colorado state tax based on either a fixed amount or percentage: <input type="checkbox"/> I elect to have \$ _____ withheld from each benefit payment <input type="checkbox"/> I elect to have _____ % withheld from each benefit payment

ELECTRONIC COMMUNICATION

Monthly direct deposit advices, as well as annual 1099-R tax forms, are available electronically on members' Member Self-Service Portal accounts at www.myderp.org. A member can view and print these forms when necessary by securely logging into his/her account. DERP will not mail these items unless a written request is received from the member.

DERP ID: _____

MEDICAL/DENTAL/VISION INSURANCE PARTICIPATION

For surviving spouses, DERP contributes to monthly insurance premiums provided the surviving spouse is enrolled in one of the group insurance plans offered by DERP. The contribution is called the **Insurance Premium Reduction benefit**, or **IPR benefit**. If a surviving spouse chooses to not enroll in one of the group insurance plans through DERP, he/she does not receive the IPR benefit. The amount of the IPR benefit is based on the deceased member's years of service and Medicare eligibility status—which is usually age 65. DERP does not contribute the IPR benefit to non-spousal beneficiary insurance coverage.

I elect to participate in DERP's group medical, dental, and/or vision insurance: ☐ Yes ☐ No ☐ Continue

- If you checked **yes**, please complete the appropriate insurance enrollment form and submit with this application.
- If you checked **no**, you are acknowledging your understanding that you are only able to enroll in a DERP group insurance plan during the annual Open Enrollment period or if you have a qualifying life status change (LSC) and complete the appropriate enrollments within 30 days of the qualifying LSC.
- If you checked **continue**, the insurance plans you were previously enrolled in through DERP will continue with no break in coverage.

CONFIRMATION

By signing below, I am confirming all choices related to the DERP retirement benefit as shown above. Additionally, I have read all parts of this application and understand the information as it has been presented to me and all my questions have been answered to my satisfaction. I understand that, in addition to this application, I am required to supply supporting documentation, as explained to me by the DERP staff, before my retirement benefit payments can commence.

THIS FORM MUST BE NOTARIZED

Signature: _____

Date signed: _____

State of _____)

City of _____)

County of _____)

The foregoing instrument was signed and acknowledged before me this _____ day of _____, _____.

WITNESS my hand and official seal.

Notary Public

My commission expires _____

***Keep a copy of this completed document for your records.**