Reinstatement After Disability Benefits/Recurrence of Disability - Instructions

ABOUT THIS FORM

Use this form to do either of the following:

- Discontinue your disability benefit and reinstate to active membership.
- Report a recurrence of disability within six months of a reinstatement to active membership.

Reinstatement allows you to voluntarily terminate your disability benefit and reinstate to active membership (even if you are or will be working for a non CalSTRS-covered employer) at any time after your disability benefit effective date.

Before reinstating, consider the following:

Subsequent Service Retirement

Your earliest service retirement date must be at least one day after your reinstatement date. If you have not been medically released to work, your earliest service retirement date can be no earlier than one year after your reinstatement date. Be sure to request an estimate so that you know how your benefit will change.

If you are planning to purchase service credit when you are reinstated, your service credit purchase must be paid in full prior to your subsequent service retirement date.

Beneficiary Options

Upon reinstatement, any option you elected at the time of your disability retirement will be void as of the effective date of your reinstatement.

If you return to a disability benefit within six months of your return to work date due to a recurrence of your original disability, you will retain the same option and same option beneficiary that you designated at the time of your initial disability retirement.

Health Insurance Deductions

If CalSTRS is deducting health insurance premiums from your benefit and you decide to reinstate, you will need to make payment arrangements with your health insurance provider when you reinstate.

Medicare Deductions

If CalSTRS is paying your Medicare Part A or deducting your Medicare Part B premiums, you will need to make payment arrangements. To arrange payment, contact the Social Security Administration at 800-772-1213.

When you retire again, you'll need to reapply for the CalSTRS Medicare Premium Payment Program, if available. (Currently, this program is not being offered to members whose most recent retirement effective date is on or after July 1, 2012.)

SECTION 1: MEMBER INFORMATION

Include your mailing and email addresses, and home or alternate telephone number, so we can contact you if we have any questions. If you know it, include your Client ID instead of your Social Security number. You can find your Client ID on your Retirement Progress Report.

SECTION 2: REINSTATEMENT INFORMATION

Complete this section if you would like to terminate your disability benefit. Your monthly benefit will end as of your reinstatement date.

Be sure to notify your employer that you are reinstating to active membership.

For additional information about reinstatement, including how your future benefit will be calculated, visit CalSTRS.com/publications to read the *Member Handbook*.

SECTION 3: REQUEST TO RETURN TO DISABILITY BENEFITS

If you experience a recurrence of your original impairment after reinstatement, you may complete this section to request to return to disability benefits.

You will also need to provide medical documentation to substantiate the recurrence of the original disability occurred within six months of your return to work date. If the recurrence is substantiated, you will maintain the same member benefit payment amount as before your reinstatement, regardless of the service credit you performed during the reinstatement. Your former disability benefit will become payable as of the first day of the month in which the recurrence of the disability occurred or the last day you performed compensated creditable service.

If CalSTRS determines the recurrence of the original disability occurred more than six months after the date you returned to work, you will need to accumulate at least one year of service credit after the date your disability benefit was terminated before you will be eligible to reapply for a disability benefit.

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SECTION 4: REQUIRED SIGNATURES

Check all boxes that apply to your current and previous marital status. (You may check more than one)

CONTACT US

If you have questions regarding this form or reinstatement after disability benefits, send us an online message using your *my*CalSTRS account or at CalSTRS.com/contact-us or call 800-228-5453.

SUBMITTING YOUR APPLICATION

Hand Delivery

Hand deliver your application to a local CalSTRS benefits planning office. For a current list of locations, visit CalSTRS.com/forms-drop.

Mail Your Application

CalSTRS
P.O. Box 15275, MS 43
Sacramento, CA 95851-0275

Overnight Delivery

If you are using a mailing service such as UPS or FedEx, send your application to:

CalSTRS Member Services
100 Waterfront Place
West Sacramento, CA 95605

Fax Delivery

916-414-5784

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[For CalSTRS' Official Use Only]

California State Teachers' Retirement System
P.O. Box 15275, MS 43
Sacramento, CA 95851-0275
800-228-5453
CalSTRS.com

Please read the instructions before completing this form. By signing this form, you are certifying that you fully understand the impact of reinstatement to your future retirement benefits.

Section 1: Member Information

Provide either your Client ID or Social Security number.

CLIENT ID

SOCIAL SECURITY NUMBER

LAST NAME

FIRST NAME MI

MAILING ADDRESS

CITY STATE ZIP CODE

EMAIL ADDRESS HOME TELEPHONE

Section 2: Reinstatement Information

☐ I wish to terminate my disability benefits and reinstate to active member status.

Effective date of reinstatement: MM / DD / YYYY

If a physician is releasing you to work, provide a copy of the medical release record. In addition, depending on your reinstatement date, you may have an overpayment of disability benefits that would need to be returned to CalSTRS.

If you are returning to a CalSTRS-covered position, complete the following.

SCHOOL DISTRICT

CONTACT NAME TELEPHONE NUMBER

Section 3: Return to Benefits Request

Complete this section to request to be reinstated to disability benefits.

Required:

☐ Within six months of my return to work, I experienced a recurrence of my original disability.

☐ I have attached medical documentation to substantiate my recurrence.

Required if your doctor has provided you with work restrictions:

☐ I have attached verification of my doctor's restrictions, my reasonable accommodation request, and the school district's official response.

Required if recurrence occurred during CalSTRS covered employment:

☐ I have attached school documentation to verify my last day of work and last day of compensation.

Section 4: Required Signatures

Check all that apply to your current and previous marital status.

☐ I am married or registered as a domestic partner and both our signatures are below.

☐ I am married or registered as a domestic partner and my spouse or registered domestic partner did not sign below. I have completed the *Justification for Non-Signature of Spouse or Registered Domestic Partner* form.

☐ I have never been married or in a registered domestic partnership, OR I am widowed or my registered domestic partner has died.

☐ I have been divorced or have terminated a registered domestic partnership and my former spouse or partner was awarded a portion of my CalSTRS benefits.

☐ I have been divorced or have terminated a registered domestic partnership and my former spouse or partner was *not* awarded a portion of my CalSTRS benefits.

Required Signatures

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement, including a false statement regarding my marital status, for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

MEMBER SIGNATURE	DATE (MM/DD/YYYY)
CURRENT SPOUSE'S OR REGISTERED DOMESTIC PARTNER'S SIGNATURE	DATE (MM/DD/YYYY)
SPOUSE'S OR PARTNER'S PRINTED NAME (LAST, FIRST, INITIAL)	

CLEAR PRINT