CALSTRS
HOW WILL YOU SPEND YOUR FUTURE?

DS0318

California State Teachers'
Retirement System
Disability Services – MS 43
Post Office Box 15275
Sacramento, CA 95851-0275
916.229.3870 / Toll-Free: 1.800.228.5453 / TTY: 916.229.3541
www.calstrs.com

Member's SSN: - -	Member's Name: (Last) (First) (M/I)

ONE YEAR FINAL COMPENSATION

☐ I certify pursuant to the district bargaining agreement, the present value payment for one year final compensation will be made to CalSTRS within 30 days of billing for the above captioned member.

MEMBER'S EMPLOYMENT DATA

Dates of employment with this district: (Mo./Day/Yr.) From: Thru:	Current Status: ☐ Paid sick leave ☐ Unpaid leave ☐ Resigned ☐ Differential pay ☐ Still working ☐ Terminated

I certify that this member's salary was reduced because of a reduction in school funds. This entitles him/her to use any three non-consecutive years for final compensation.

School Years Reduced:

If either of these dates below change, please send a corrected copy of this form to CalSTRS immediately.

Last day of actual performance on the job: (Mo./Day/Yr.)	Last day of compensation for service performed, differential and/or sick pay: (Mo./Day/Yr.)
Days of absence in the current school year:	Days of absence in the prior school year:
Type of contract: ☐ Full-time ☐ Less than full-time →	If less than full-time, please indicate type of position: ☐ Hourly ☐ Daily ☐ Annual Contract ☐ Percentage of Contract
Did member work less than full-time due to illness? ☐ No ☐ Yes →	If Yes, when did member begin working less than full-time? (Mo./Day/Yr.)

Are dismissal proceedings contemplated or pending? ☐ No ☐ Yes - If Yes, please explain:

Member's SSN: - -	Member's Name: (Last) (First) (M/I)

INCOME PROTECTION PLAN

Is a monthly benefit payable from any income protection plan such as indemnity or annuity? ☐ No ☐ Yes →	If Yes, were the premiums paid for by the school district? ☐ No ☐ Yes

If the premiums were paid by the school district, please complete the section below:

Company Name: ______________________________

Address: ______________________________
(Street Number or Post Office Box)

____
(City) (State) (Zip Code)

Telephone Number: ( ) ______________

Remarks:

WORKERS' COMPENSATION

Has member applied for benefits through Workers' Compensation? ☐ No ☐ Yes →	If Yes, the benefits are paid directly to: ☐ Member ☐ School District
Weekly rate of benefits? ($)	Effective date of benefits? (Mo./Day/Yr.)
Date of injury? (Mo./Day/Yr.)	Were benefits awarded as lump sum? ☐ No ☐ Yes

Address of carrier or company handling the claim

Company Name: ______________________________

Address: ______________________________
(Street Number or Post Office Box)

____
(City) (State) (Zip Code)

Telephone Number: ( ) ______________

Remarks:

CERTIFICATION

I certify that the foregoing information is true and correct to the best of my knowledge and is in accordance with the California Education Code.

Authorized Signature:		Date: (Mo./Day/Yr.)
Type Name:	Title:	Telephone Number: ( )