TR-13
Rev. 10/86
Disability Determination

TEACHERS' RETIREMENT SYSTEM OF FLORIDA
APPLICATION FOR DISABILITY RETIREMENT

PO Box 9000
Tallahassee, FL 32315-9000
(850) 488-2968
Toll Free: 1-877-738-3725

Date _____
SSN _____

In accordance with the provisions of the law governing the operation of the Teachers' Retirement System of Florida, the undersigned, a member of the System, does hereby make application for disability retirement.

Present (or last) Employer _____

Name of Position Held _____ Date of Birth _____

(_____) Option 1. (Maximum Annuity with no Refund to Beneficiary)

(_____) Option 2. (Reduced Annuity with Refund to Beneficiary)

(_____) Option 3. (Reduced Benefit to be Continued to Surviving Spouse for Life)

(_____) Option 4. (Reduced Benefit with one-half Thereof to Continue to the Surviving Spouse for Life)

The beneficiary whom I should like to receive the benefit or refund under the option selected at my death is my (A beneficiary should be designated regardless of the option selected)

Relationship	Name of Beneficiary	Date of Birth

Address _____

I am ( ) am not ( ) receiving and will ( ) will not ( ) receive a pension or annuity from any other state, county, or municipality or other taxing district.

My services terminated or will terminate _____ 19 _____

Signed (DO NOT PRINT) _____

Address for Check _____

_____

_____ Zip code _____

Approved by Employer _____
Name Title

APPLICANT MUST SIGN IN THE PRESENCE OF NOTARY PUBLIC

Notary:

State of _____, County of _____ The above named person who has sworn to and subscribed

before me this_____ day of _____20___ and who is personally known _____ or produced

_____identification.

_____
Signature of Notary Public

_____
Print, Type or Stamp Commissioned Name of Notary Public