Office of the New York State Comptroller
New York State and Local Retirement System
Employees' Retirement System
Police and Fire Retirement System
110 State Street, Albany, New York 12244-0001

SURVIVOR'S BENEFIT PROGRAM

Eligibility of Retired Employee for Survivor's Benefit

RS 6355-I

(Rev. 3/07)

PART A - TO BE COMPLETED BY DEPARTMENT OR AGENCY *(See instructions on reverse)*

1. Name (Last)____(First)__________________________ (MI)________ **2**. Social Security Number _______________________

3. Date of Birth____________________ **4**. Date of Appt. ____________________ **5**. Agency Code ____________________ **6**. Payroll Item No. ________________________

7. Name(s) of Retirement System(s) _____________________________________ **8**. Ret. Reg. No. ____________________ **9**. Title _________________________________

10. Eligibility - Check box "a" and other applicable boxes (if box 'a' does not apply, see detailed instructions on reverse).

a. ☐ Employee had ten years of full-time **State** service within the last 15 years. (Annual salary of at least 1,000 hours times the state minimum wage during such period or regularly scheduled work week of 20 hours or more).

b. ☐ Employee retired from the system named in number 7 effective. ___________________________ (Date)

c. ☐ Employee retired from the State University or Department of Education optional retirement program after attaining age 55 and began receiving retirement allowance within 90 days of last day on the payroll.

d. ☐ Employee terminated state service effective ___________________________ (Date) after attaining age 62.

e. ☐ Employee laid off effective ___________________________ (Date) and retired within one year of layoff date.

11. I certify that the information above is as shown in the records at this agency and I believe the same are true and correct. This employee has received Form VO 1860.

Signature ____ Title ____ Phone No.______________________

Agency____ Address ____ Date _________________________

PART B - TO BE COMPLETED BY SURVIVOR'S BENEFIT PROGRAM

☐ ELIGIBLE ☐ INELIGIBLE
REASON:

Signature ____ Date ________________________

PART C - TO BE COMPLETED BY EMPLOYEE AT TIME OF INITIAL RETIREMENT (DO NOT USE AS A CHANGE OF BENEFICIARY IF PREVIOUSLY RETIRED.)

DESIGNATION OF BENEFICIARY — If you are not a member of a retirement system or pension plan supported by State funds or if you are a member but have not designated a beneficiary to such system to receive retirement benefits (because you have chosen Option 0), you should check box A, and designate a beneficiary below for the Survivor's Benefit Program. If you are a member of a retirement system and have selected an option under which you have designated a beneficiary (**any** option other than 0), the survivor's benefit **must** be paid to the **same** beneficiary designated to the retirement system. Therefore, box B should be checked.

A. ☐ I have selected Option 0 and have, therefore, not designated a beneficiary to a retirement system supported by State funds to receive retirement benefits. I authorize the Comptroller to pay to the beneficiary named below any survivor's benefit due on my behalf. I understand that I can change this designation at any time. **(Note: Also check A. if not a member of any retirement system.)**

(COMPLETE DESIGNATION OF BENEFICIARY(IES) ONLY IF YOU HAVE SELECTED OPTION 0 OR IF YOU DO NOT BELONG TO ANY RETIREMENT SYSTEM)

DESIGNATION OF PRIMARY BENEFICIARY(IES) *USE YOUR BENEFICIARY'S GIVEN (FIRST) NAME, (MARY SMITH, NOT MRS. JOHN SMITH) PLEASE PRINT PLAINLY OR TYPE.*

Name____

Relationship______________________________ Birth Date____________

Soc. Sec. No.* ______________________________ Sex____________

Address (Street, City, State, Zip)________________________________

Name____

Relationship______________________________ Birth Date____________

Soc. Sec. No.* ______________________________ Sex____________

Address (Street, City, State, Zip)________________________________

DESIGNATION OF CONTINGENT BENEFICIARY(IES)

If all the above named beneficiaries die before I do, any amount payable on my behalf should be paid to the following. If I have named more than one beneficiary, it is my intention that those living at the time of my death should share any benefit equally. This designation revokes all previous designations I have made.

Name____

Relationship______________________________ Birth Date____________

Soc. Sec. No.* ______________________________ Sex____________

Address (Street, City, State, Zip)________________________________

Name____

Relationship______________________________ Birth Date____________

Soc. Sec. No.* ______________________________ Sex____________

Address (Street, City, State, Zip)________________________________

to share and share alike unless otherwise specified of those surviving the death benefit payable under the Survivor's Benefit Program as the result of my death after retirement. I reserve the right to change the above beneficiaries at any time without their consent. I hereby direct that, should I survive the before mentioned beneficiaries, the amount which otherwise would have been payable to them as hereinabove set forth, shall be paid to my Estate or to such other beneficiary as I shall hereafter designate, by written designation filed with the Comptroller in accordance with the rules and regulations prescribed. I understand that the above designation of beneficiary(ies) is for my death benefit under the Survivor's Benefit Program only, and does not affect any designation of beneficary(ies) made in conjunction with my retirement benefits.

B. ☐ I have selected an option other than 0 and understand that the survivor's benefit must be paid to the same beneficiary(ies) designated to the retirement system.

THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC.

Employee's Signature ____

Street Address____ City ____________________ State ______ Zip Code___________

ACKNOWLEDGEMENT

To be Completed by a Notary Public

State of ____ County of ____ ss:

On this ___________ day of _____________________, _______, before me personally appeared ___________________________ to me known and known to me to be the same person described in and who executed the foregoing instrument, and __he duly acknowledged to me that __he executed the same.

(Signature of Officer) ____

Notary Stamp Must Be Affixed

PERSONAL PRIVACY PROTECTION LAW

In accordance with the Personal Privacy Law, you are hereby advised that pursuant to the Retirement and Social Security Law, the Retirement System is required to maintain records. The records are necessary to determine eligibility for and to calculate benefits. Failure to provide information may result in the failure to pay benefits. The System may provide certain information to participating employers. The official responsible for maintaining these records is the Director of Member and Employer Services, New York State and Local Retirement System, 110 State Street, Albany, NY 12244; Telephone Number (518) 474-4608.

***SOCIAL SECURITY DISCLOSURE REQUIREMENT**

In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of the Social Security Account Number is mandatory pursuant to Sections 11, 34, 311 and 334 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

INSTRUCTIONS FOR COMPLETION OF FORM RS 6355

PURPOSE This form is to be used by a State department or agency to report the separation of an employee who meets the eligibility requirements of the Survivor's Benefit Program for **retired** employees. The form is also to be used for designation of a beneficiary by the separating employee at the time of separation, when required.

PREPARATION Type an original and one copy. Complete items in Part A and have employee complete Part C. All items must be completed; indicate "none" or "unknown" if necessary, and check appropriate boxes. Forward original to Survivor's Benefit Program and give copy to employee.

PART A

ITEM NO. 3 If employee does not retire from a public pension plan, a **copy of a certificate of birth or other proof of his/her age must be attached to this form.**

ITEM NO. 4 Enter the **original** date of appointment to the first State position held by the employee.

ITEM NO. 7 Enter the name or names of any retirement systems or pension plans supported by State funds of which the employee was an **ACTIVE**, vested, or discontinued member at time of separation. If employee's status was other than **ACTIVE**, so indicate, e.g., Employees' Retirement System (discontinued). If employee was not a member of either the NYS Employees' Retirement System or Police and Fire Retirement System, include a detailed statement of employment history. If employee was a member or prior member of more than one retirement system, list all retirement systems.

ITEM NO. 8 Enter a registration number for each pension plan entered in Item No. 7. If a member of more than one system, list all registration numbers.

ITEM NO. 10 Periods during which an employee was off the payroll on authorized leave of absence shall be counted as State Service, not exceeding a total of three months in any one calendar year and not exceeding three months in any one continuous period of such absence.

A legislative or seasonal employee who served in a position wherein the nature of service is not continuous throughout the year but recurs or is expected to recur in each successive year in essentially the same form shall be deemed to have been on authorized leave of absence during the period between successive annual periods of service.

If the employee was compensated on an annual salary basis but was paid over a period of less than 12 months, he/she is deemed to have been actively on the payroll during the entire period covered by the payment of that annual salary.

An employee who retired from State service while off the payroll on **authorized** leave of absence is deemed to have been in State service upon such retirement. An employee who resigns or otherwise terminates State service while off the payroll on **authorized** leave of absence is deemed to have terminated State service upon the actual effective date of such termination and is deemed to have been in State service on such actual date of termination. An employee who is laid off from his or her position because of the curtailment of the State services, is considered to be on an authorized leave without pay for one year following the layoff.

Item No. 10 should be checked and completed as follows:

1. **Box a.** should be checked in every case to confirm eligibility. If Box a. does not apply, forms should not be submitted except upon specific request of the Survivor's Benefit Program. If it is not certain whether Box a. applies, forms should be submitted.
2. **Box b.** should be checked and completed if employee is retiring from a public pension plan.
3. **Box c**. should be checked in addition to a. and b. if employee is retiring from State University or Department of Education optional retirement program.
4. **Box d.** should be checked and completed if employee is not retiring from a public pension plan but is leaving State service after attaining age 62 and proof of age must be attached to this form.
5. **Box e.** should be checked and completed if employee's separation from service was due to a layoff (rather than a resignation or termination). Retirement date shown in Box b. must be within one year from date of layoff.

A detailed statement of employment history must be attached to Form RS 6355 to substantiate the requirement of ten years of full time service for employees in the following categories or agencies:

1. **Teachers' Retirement System Member**
2. **TIAA-CREF Member**
3. **Non-retirement System Member**
4. **Unclassified Service**
5. **Legislative Branch**
6. **Judicial Branch**
7. **Cornell University and Alfred University**
8. **Forest Fire Observers (Conservation)**
9. **Palisades Interstate Park Commission**

PART C

This employment history should show all appointments, status changes, leaves, separations, and their effective dates. If a complete employment record is maintained by the agency, a photocopy will be sufficient. If not, the agency should reconstruct the employee's work history from available records. If service for any period was other than full time (regular work schedule of at least 20 hours per week or annual salary at least $2,000) please so indicate on the statement.

This part must be completed by the eligible employee in **every** case. If the employee is not a member of a pension plan supported by State funds or if he/she is a member but has **not** designated a beneficiary to receive his/her retirement benefits, he/she should check Box a., designate a beneficiary as indicated, sign his/her name, and enter date and address.

The employee must enter the **full** name (abbreviations not acceptable), complete date of birth (list approximate age if exact date unknown) and Social Security number (if known) of his/her beneficiary. If the beneficiary is a married female, her given name must be entered on the form **(Mrs. John Smith is not acceptable).** Be sure beneficiary's address is complete - number, street address, city, state and zip code.

NOTE: The employee may designate more than one beneficiary. If he/she wishes to do this he/she should merely list the names and addresses of such persons. Benefits will be divided **equally** among them unless otherwise specified. Attachments to your beneficiary form are not acceptable. If needed you may double up on lines; including names, birthdates, addresses and relationships.

The employee may designate contingent beneficiaries. He/she may not place any restrictions upon his/her designation such as "in trust for" or "upon reaching age 21". If the employee has designated a beneficiary to a pension plan supported by State funds to receive his/her retirement benefits upon his/her death, he/she should check Box b., sign his/her name and enter the date and his/her address. He/she should not enter the name of beneficiary on the Form RS 6355.

If an eligible employee fails to designate a beneficiary to receive his/her retirement benefits, or on Form RS 6355 as described above, the survivor's benefit will be paid to his/her estate. In some cases, the payment may not be made in accordance with the employee's wish. For this reason, it is imperative that all employees designate a beneficiary as required and that such designation be complete, accurate, and legible.