

**KENTUCKY PUBLIC PENSIONS AUTHORITY**

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Form 6000
Revised 09/2026

Notification of Retirement

Please read the instructions for each section and complete all information requested in Sections A-G. Section H must be completed by your current employer. Section I must also be completed if applying for disability retirement.

Section A: Member Information

You must attach a copy of your birth verification.

Member Name:		Member ID:	
KPPA will update contact information for your retirement account based on the details provided below.			
Address:	City:	State:	Zip Code:
Personal Email Address:		Phone:	
Date of Birth:	Sex: ☐ Male ☐ Female		

Please note: If your current legal name or your beneficiary's current legal name is not the same as the name on the date of birth verification you have submitted we will also require verification of name change. Acceptable name change verification includes:

- State Issued Driver's License or State Issued ID
- Marriage Certificate
- Court Order
- U.S. Passport
- Immigration and/or Naturalization Documents
- Social Security Card

You must provide a termination date and retirement date below.

Termination Date: _____
Month Day Year

Retirement Date: _____ 1, _____
Month Year

(YOUR TERMINATION DATE MUST BE PRIOR TO YOUR RETIREMENT DATE.)

(YOUR RETIREMENT DATE MUST BE THE FIRST DAY OF THE MONTH.)

Section B - Type of Retirement and Retirement Systems

Check the appropriate box or boxes to indicate the types of retirement and retirement systems from which you intend to retire. (Check all that apply). If applying for normal or early retirement, you may not submit this form more than 6 months prior to your retirement date. You must terminate employment to be eligible for early or normal retirement benefits.

Disability Retirement applicants must complete Section I.

☐ NORMAL OR EARLY RETIREMENT	☐ DISABILITY RETIREMENT
☐ Kentucky Employees Retirement System - KERS (state employees, health departments, universities)	
☐ County Employees Retirement System - CERS (city, county, local governments, classified employees of boards of education)	
☐ State Police Retirement System - SPRS (full-time officers of Kentucky State Police)	

Other State Administered Retirement Systems

If you have an account in one of the systems administered by the Kentucky Public Pensions Authority (KERS, CERS, or SPRS) and in one of the other state administered retirement systems (listed below), you will need to complete the retirement application for the other system in order to be eligible for reciprocal benefits from all systems.

- ☐ **Teachers' Retirement System - (certified employees of boards of education)**
- ☐ **Legislators' Retirement Plan - LRP (State Senators and Representatives)**
- ☐ **Judicial Retirement Plan - JRP (Judges)**

Section C - Retirement Account Beneficiary Designation

Your account beneficiary can only be one person, a trust or your estate. Indicate your beneficiary by checking one of the beneficiary types below and providing the necessary information. This designation will become invalid if you file a new Form 6000 prior to your effective retirement date or if this form is voided.

Member Name:	Member ID:
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☐ Person Attach a copy of this person's birth verification to this form with your Member ID written on it.			
Name:		Social Security Number:	
Date of Birth:		☐ Male ☐ Female	
Relationship:		☐ Check this box if this person is also your legal spouse.	
Address:	City:	State:	Zip Code:

☐ My Estate No additional information required.

☐ Trust (select one): ☐ Living Trust ☐ Special Needs Trust ☐ Testamentary Trust (no additional information or trust document is required)			
The following information is required to designate a living trust. <u>You must write the name of the trust as it appears in the trust document and submit a copy of the trust with this form.</u> A charitable organization or a religious charity cannot be named as beneficiary unless it is a trust.			
Name of Trust:		Trust Tax EIN or special needs trust beneficiary Social Security Number :	
Trustee Contact Information: Our office will contact the trustee listed below following your death.			
Name:		Phone:	
Address:	City:	State:	Zip Code:
If the trust is a special needs trust, submit a copy of the trust beneficiary's birth verification with this form with your Member ID written on it and complete the section below.			
Trust's Beneficiary:		Beneficiary's Date of Birth:	

Section D - \$5000 Death Benefit from Kentucky Public Pensions Authority - Complete only if eligible
To be eligible for this benefit, you must be a retired member receiving a monthly benefit on the date of your death from Kentucky Public Pensions Authority based on a minimum of 48 months of service.

If eligible for this benefit, you may name one death benefit beneficiary. This designation is not valid if you designate more than one beneficiary. Your estate will become your default beneficiary if this designation is deemed to be invalid. This designation may be changed at any time prior to your death by filing a properly completed Form 6030, Death Benefit Designation.

Member Name:	Member ID:
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☐ **Person** You may only name one person as your death benefit beneficiary.

Name:		Social Security Number:	
Date of Birth:	Relationship:		☐ Male ☐ Female
Address:	City:	State:	Zip Code:

☐ **My Estate** No additional information required.

☐ **Trust (select one):** ☐ Living Trust ☐ Special Needs Trust ☐ Testamentary Trust (no additional information or trust document is required)

The following information is required to designate a living trust. You must write the name of the trust as it appears in the trust document and submit a copy of the trust with this form. A charitable organization or a religious charity cannot be named as beneficiary unless it is a trust.

Name of Trust:	Trust Tax EIN or special needs trust beneficiary Social Security Number :		
Trustee Contact Information: Our office will contact the trustee listed below following your death.			
Name:	Phone:		
Address:	City:	State:	Zip Code:
If the trust is a special needs trust:			
Trust's Beneficiary:	Beneficiary's Date of Birth:		

☐ **Funeral Home** Please enclose a copy of the Funeral Home License with your Member ID written on it.

Funeral Home Legal Name:		Funeral Home License Number:	
Funeral Home Tax ID:	Contact Name:	Phone:	
Address:	City:	State:	Zip Code:

Section E - Authorization for Deposit of Retirement Payment**Complete this section to authorize deposit of your retirement benefit directly into your account at a financial institution.**

Financial Institution Information: The financial institution may be a bank, savings bank, savings and loan association, credit union, or similar institution that is a member of the Automated Clearing House (ACH). Your direct deposit institution may be changed at any time by filing a properly completed Form 6130, Authorization for Deposit of Retirement Payment.

Financial Institution Name:

Depositor Routing Number:

Depositor Account Number:

Account Type:

☐ Checking☐ Savings**For your convenience:**

The sample check shows where to locate the required bank information to complete your Direct Deposit.

The sample check is a standard personal check. At the top left, it says 'My Name', 'My Address', and 'My City, State, & Zip'. At the top right, there is a box for 'DATE' and a box for the amount in dollars, followed by 'DOLLARS'. Below the date box is the text 'PAY TO THE ORDER OF'. In the center, there is a box for 'Bank Name' and 'Bank Address'. Below that is a 'MEMO' line. At the bottom, there is a MICR line with the numbers '+1:001862862: 925 525 1 152'. Below the MICR line, there are three labels: '9 Digit Bank Routing Number' pointing to '001862862', 'Your Account Number' pointing to '925 525', and 'Check Number' pointing to '1 152'.

Required Documents: Please indicate the documentation you are submitting with this form.

For deposits to a Checking Account:

I have attached to this form

☐ a VOIDED personalized check☐ verification from my financial institution

For deposits to a Savings Account:

I have attached to this form

☐ verification from my financial institution**Attach Voided Check Here:**

(Attach Voided Check Here)

I acknowledge that electronic payments to the designated account must comply with the provisions of U.S. law, as well as the requirements of the Office of Foreign Assets Control (OFAC) and National Automated Clearing House Association (NACHA) regulations. I certify that the entire payment that the Kentucky Public Pensions Authority sends electronically to the financial institution I have designated, is not subject to being transferred to a foreign bank. I agree to notify the Kentucky Public Pensions Authority in writing immediately if the payment becomes subject to transfer to a foreign bank in the future.

If all required forms have been completed properly and returned by the end of the month prior to your retirement date, the first check will be deposited or mailed on the *14th* of the first month of retirement. **Due to deadlines required to establish a direct deposit, your first benefit payment is not guaranteed to be deposited to your account.**

Many benefit payments for the first month of retirement are mailed. After the initial payment, the monthly benefit will be deposited to the retired member's account on the *14th* of each month. If the *14th* of the month is a weekend or holiday, the benefit will be mailed or deposited the business day prior. Members are required to have the monthly retirement benefit deposited directly to their bank accounts, unless their bank does not participate in the Automated Clearing House or the member does not have an account with a financial institution.

Section G - Certification of Bona Fide Separation from Service and Notification of Retirement

Subject to penalty of KRS 523.100: I acknowledge that federal and state law both require a bona fide separation from service with agencies participating in the Kentucky Public Pensions Authority or entities affiliated with participating agencies in order for the Kentucky Public Pensions Authority to pay a retirement benefit or to pay a refund of a retirement account.

If I am retiring, I affirm that I have had a separation from service with agencies participating in the Kentucky Public Pensions Authority or entities affiliated with participating agencies, or that I will have a separation from service with agencies participating in the Kentucky Public Pensions Authority or entities affiliated with participating agencies prior to my retirement date. I also affirm that I do not have a prearranged agreement to return to a participating agency or entities affiliated with participating agencies after my separation from service.

If I am taking a refund of my retirement account, I affirm that I have had a separation from service with agencies participating in the Kentucky Public Pensions Authority or entities affiliated with participating agencies. I also affirm that I do not have a prearranged agreement to return to a participating agency or entities affiliated with participating agencies after my separation from service.

I understand that the term "separation from service" as used in this affidavit means a complete severance of any kind of employment relationship (including but not limited to a relationship as an independent contractor or leased employee) with agencies participating in the Kentucky Public Pensions Authority or entities affiliated with participating agencies.

I understand that the term "prearranged agreement" as used in this affidavit means any contemplation of return to employment with agencies participating in the Kentucky Public Pensions Authority or entities affiliated with participating agencies.

I understand that the terms "agencies participating in the Kentucky Public Pensions Authority" and "participating agency" as used in this affidavit are to be construed in a broad manner, and include not only the agency itself, but also any entities affiliated with participating agencies, regardless of whether such entities are holding themselves out as legally separate entities.

I acknowledge that prior to accepting employment within twelve (12) months of my retirement date with an agency participating in the Kentucky Public Pensions Authority or entities affiliated with participating agencies, I have a duty to report such employment in writing to the Kentucky Public Pensions Authority pursuant to 105 KAR 1:390.

I acknowledge and understand that if I fail to comply with federal and state law regarding bona fide separation from service and break in service, my retirement shall be voided and I shall repay all retirement allowances, dependent child payments, and health plan premiums paid by the Kentucky Public Pensions Authority.

I certify the information in this Notification of Retirement is correct and that my employer has been informed of my intent to terminate employment on the date indicated on this form if applying for early/normal retirement. I understand the Kentucky Public Pensions Authority will send an estimated retirement allowance. **I acknowledge my estimated retirement allowance and benefits are subject to post retirement audit and adjustment after retirement. I acknowledge that I have full understanding that any person who provides a false statement, report, or representation is subject to penalty in accordance with KRS 523.100.**

Member's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____

NOTE: Signature of Member is required. Signature of either the Spouse **or** a Witness is also required.

Failure to sign form and have your signature witnessed by either your spouse or another person will result in the form being voided.



Section H - Employer Certification of Leave Balances and Final Salary

Section H must be completed by your current employer and returned to the Kentucky Public Pensions Authority (KPPA) in order to include future salary, service and sick and compensatory leave balances in your estimated retirement allowance. Section H must be submitted no later than 30 days prior to the effective retirement date. If you are currently employed by more than one participating employer, each employer should complete a copy of Section H. If Section H is not submitted by the prescribed deadline, the KPPA will **exclude** all leave balances, future service and salary from the estimated retirement allowance. **Your estimated retirement allowance and benefits are subject to post retirement audit and adjustment after retirement.**

Employer Name:

Employer Code:

Member Name:

Member ID:

Termination Date:

Employer's Report of Leave Balances as of:

Does your agency participate in a sick leave program administered by KPPA? ☐ Yes ☐ No

If yes above, select the type of sick leave plan: ☐ Standard ☐ Alternate

Does the above member work an average of 21 days per month? ☐ Yes ☐ No

If no above, please provide an Alternate Average Working Days Per Month: _____

Standard Sick Leave Program: If participating in the standard sick leave program, please provide the following information.

Note: Contributions should not be withheld from standard sick leave lump sum payouts.

Accumulated Sick Leave (in hours):

Hours in a Sick Leave Day:

Alternate Sick Leave Program: If participating in the alternate sick leave program, please provide the following information.

Note: Contributions should be withheld from alternate sick leave lump sum payouts.

Accumulated Sick Leave (in days):

Hours in a Sick Leave Day:

Estimated Compensation to be Paid for Sick Leave:

School Board Certification (*school board employees only*): Indicate the number of actual days the member will have worked through the expected termination date. If the days occur in different school years, please list each school year separately below.

Actual Days Worked through Expected Termination Date	
School Year	Number of Actual Days



Following page. You must complete the Employer Certification at the end of Section H.

**Section H Continued - Employer Certification of Leave Balances and Final Salary**

Employer Name:	Employer Code:
Member Name:	Member ID:

Note to Employer:

KPPA will provide calculations to the member based upon the information you certify below. Due to the reporting process there may be a delay from the time you report it to the time it is available for use in the calculation. For this reason we ask that you verify the actual earned wages for the three months prior to the date you are completing this certification and each month thereafter through member's anticipated date of termination.

Employer's Report of Final Salary

You may select from the following payment reasons: Regular Pay, Regular Pay with Additional Creditable		
Posting Month	Payment Reason	Salary

Employer Certification

I certify that the leave balances and estimated final salary information provided above is accurate based upon our agency's records. I state that I have full knowledge of the penalty in KRS 523.100 related to falsification of records and that the information provided is true and accurate.

Printed Name of Agency Official: _____

Title: _____ Agency Phone Number: _____

Signature of Agency Official: _____ Date: _____

Section I - Member's Statement of Disability

If additional space is required to answer the questions, you may use and attach additional paper.

Member Name:

Member ID:

1. List the diagnoses of the injury, illness, or disease for which you are applying for disability:

2. Describe how the diagnoses listed above on this page prevent you from performing your essential job duties:

3. Describe the history of the diagnoses listed above, including the onset or start of your symptoms or complaints:

4a. If you are a non-hazardous employee, are you claiming that you are totally and permanently disabled from performing any occupation for remuneration or profit as a result of a single traumatic event that occurred while you were performing the duties of your job or a single act of violence committed against you that was related to your job duties?

☐ Yes ☐ No

Please note: A duty related injury does not include the effects of the natural aging process, a communicable disease unless the risk of contracting the disease is increased by the nature of the employment, or a psychological, psychiatric, or stress related change unless the direct result of a physical injury.

4b. If you are a hazardous employee, are you claiming that you are disabled due to an act in line of duty by either a single act occurring while performing the principal duties of your job or a single act of violence against you that was related to your job duties?

☐ Yes ☐ No

If you answered yes to 4a or 4b, describe specific date, time, and circumstances of the duty related injury or act in line of duty below. Please attach a copy of the employer incident report to this form. Failure to attach the employer incident report will delay your disability application.



Section I is continued on the following page. You must complete the Certification at the end of Section I.

Section I Continued - Member's Statement of Disability

Member Name:	Member ID:
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Last Day of Paid Employment

Last Day of Paid Employment: The last day of paid employment is the last day for which contributions were reported and for which you were eligible to receive retirement credit. Identify the month, day, and year that is your last day of paid employment, or if you are still working or on paid leave, identify the month, day, and year that is your anticipated last day of paid employment.

Last Day of Paid Employment: _____
Month Day Year

You will be sent an estimate of disability retirement benefits, subject to post retirement audit and adjustment after retirement, based upon your last day of paid employment in a regular full-time position assuming your application for disability retirement benefits is approved. If approved for disability benefits, you will receive benefits effective the first day of the month following your last day of paid employment.

Certification and Authorization

I certify the information on this Statement of Disability, Section I, is true and correct. I acknowledge that any person who makes a false statement, report, or representation is subject to penalty pursuant to KRS 523.010 to 523.110.

I authorize the Authority, its agents, servants, and employees to have full and complete access to any and all medical records of mine, whether or not related to this injury, illness, or disease, and authorize the Authority, and its agents, servants, and employees to discuss such records as it may be necessary at any meeting of the Board in connection with my application for disability retirement benefits.

I authorize my employer to release, furnish, disclose, or discuss with the Kentucky Public Pensions Authority all records or other information regarding my employment, including but not limited to, a description of job duties performed as of the last day of my employment, a description of the accommodations, assistance, or help that was offered or attempted or reasonably available to allow me to perform my essential job duties, a report of work injuries or accidents, my personnel file, or other employee records.

Signature of Member: _____

Date: _____

Signature of Witness:

Date:
