STATE RETIREMENT AGENCY OF MARYLAND
120 EAST BALTIMORE STREET
BALTIMORE, MARYLAND 21202

VERIFICATION OF RETIREE'S DISABLED CHILD FOR SELECTION OF OPTION 2/5 BENEFICIARY

IMPORTANT: FILL IN ALL SECTIONS. PRINT IN INK OR TYPE. THIS FORM MUST BE SUBMITTED WITH YOUR APPLICATION FOR SERVICE OR DISABILITY RETIREMENT (FORM 13-23, FORM 14-24, OR FORM 98-101.)

FORM 143 (REV. 5/07)

MEMBER'S SOCIAL SECURITY NUMBER ___ - ___ - ____

RETIREMENT DATE: _____

RETIREMENT OPTION: ☐ OPTION 2 ☐ OPTION 5

MEMBER'S NAME

First Initial Last

HOME ADDRESS

Number and Street

City State Zip Code

PLEASE NOTE: In order to name your disabled child as your beneficiary under Option 2 or Option 5 of the optional forms of retirement allowance, your child must be disabled as certified by a physician in Section II of this form. An individual shall be considered to be disabled if he or she is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration.

SECTION I: RETIREE'S DISABLED CHILD

GENDER DATE OF BIRTH

M or F Month Day Year

NAME OF DISABLED CHILD

First Initial Last

DISABLED CHILD'S ADDRESS _____

SECTION II: TO BE COMPLETED BY PHYSICIAN.

Please provide medical information regarding the nature of the disability for the patient identified in Section I of this form.

Diagnosis: _____

Description of Disability: _____

_____

Is patient unable to engage in any substantial gainful activity by reason of the physical or mental impairment described above? ☐ YES ☐ NO

Is the impairment expected to result in death or to be of long-continued and indefinite duration? ☐ YES ☐ NO

Reporting physician's name and address:	Physician's signature	Specialty
	Telephone number	Date

NEED HELP?

If you need help completing this form, call a Retirement Benefits Counselor at 410-625-5555 or 1-800-492-5909.