Kentucky Public Pensions Authority
Ad Hoc Regulation Committee – Special Meeting
June 13, 2023, at 10:00 AM EST (9:00 AM CT)
Live Video Conference/Facebook Live

AGENDA

1.	**Call to Order**	**Keith Peercy**
2.	**Opening Statement**	**Legal Services**
3.	**Roll Call**	**Sherry Rankin**
4.	**Public Comment**	**Sherry Rankin**
5.	**Approval of Minutes – April 18, 2023***	**Keith Peercy**
6.	**Administrative Regulation 105 KAR 1:457***	**Carrie Bass** **Jessica Beaubien** **Jillian Hall**
7.	**Adjourn***	**Keith Peercy**

Committee Action May Be Taken

MINUTES OF MEETING
KENTUCKY PUBLIC PENSIONS AUTHORITY
AD HOC REGULATION COMMITTEE
SPECIAL CALLED MEETING
APRIL 18, 2023, AT 10:00 AM
VIA LIVE VIDEO TELECONFERENCE

At the Special Called Meeting of the Kentucky Public Pensions Authority Ad Hoc Regulation Committee held on April 18, 2023, the following members were present: Keith Peercy (Chair), Betty Pendergrass, and Jerry Powell. Staff members present were KRS CEO John Chilton, CERS CEO Ed Owens, III, Rebecca Adkins, Erin Surratt, Michael Lamb, Vicki Hale, Jessica Beaubien, Jillian Hall, Liza Welch, Ashley Gabbard, Shaun Case, Katie Park, and Sherry Rankin.

Mr. Peercy called the meeting to order.

Ms. Hale read the Legal Public Statement.

Ms. Rankin took Roll Call.

There being no ***Public Comment*** submitted, Mr. Peercy introduced agenda item ***Approval of Minutes – March 7, 2023*** *(Video 00:05:50 to 00:06:08)*. Mr. Powell made a motion to approve the minutes from the meeting held on March 7, 2023. Ms. Pendergrass seconded the motion and the motion passed unanimously.

Mr. Peercy introduced agenda item ***Administrative Regulation 105 KAR 1:220*** *(Video 00:06:09 to 00:26:30)*. Ms. Jillian Hall stated that Administrative Regulation 105 KAR 1:220 was previously presented at the March 7, 2023, KPPA Ad Hoc Regulation Committee meeting. At the meeting, the Committee requested several modifications. Ms. Hall reviewed the modified regulation with the KPPA Ad Hoc Regulation Committee. Mr. Powell made a motion to approve regulation 105 KAR 1:220 as presented, and to forward it to the full KPPA Board for its approval to file the regulation with the Office of the Regulations Compiler at LRC. Ms. Pendergrass seconded the motion and the motion passed unanimously.

Mr. Powell made a motion and was seconded by Ms. Pendergrass to ***adjourn*** the meeting. The motion passed unanimously.

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CERTIFICATION

I do certify that I was present at this meeting, and I have recorded the above actions of the Kentucky Public Pensions Authority Ad Hoc Regulation Committee on the various items considered by it at this meeting. Further, I certify that all requirements of KRS 61.805-61.850 were met in conjunction with this meeting.

_____
Recording Secretary

We, the Chair of the Kentucky Public Pensions Authority Ad Hoc Regulation Committee and Executive Director, do certify that the Minutes of Meeting held on April 18, 2023, were approved on June 13, 2023.

_____
KPPA Board Chair

_____
Executive Director

I have reviewed the Minutes of the April 18, 2023, Kentucky Public Pensions Authority Ad Hoc Regulation Committee Meeting for content, form, and legality.

_____
Executive Director, Office of Legal Services

MEMORANDUM

TO: Ad Hoc Regulation Committee ("Committee") for the Board of the Kentucky Public Pensions Authority ("Board")

FROM: Carrie Bass, Staff Attorney Supervisor, Non-Advocacy Division, Office of Legal Services
Jillian Hall, Staff Attorney, Non-Advocacy Division, Office of Legal Services
Jessica Beaubien, Policy Specialist, Non-Advocacy Division, Office of Legal Services

DATE: June 13, 2023

RE: Committee approval and recommendation of KPPA staff to present a new administrative regulation, 105 KAR 1:457, In-Line-of-Duty Survivor Benefits, to the full Board for approval to file with the Office of the Regulations Compiler at the Legislative Research Commission

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Purpose of new administrative regulation:

Kentucky Revised Statutes 61.505(1)(g) authorizes the Board to promulgate and amend administrative regulations "on behalf of the Kentucky Retirement Systems and the County Employees Retirement System, individually or collectively" as long as the regulations are consistent with the provisions of Kentucky Revised Statutes 16.505 to 16.652, 61.510 to 61.705, 78.510 to 78.852, and 61.505. 105 KAR 1:457, In-Line-of-Duty Survivor Benefits, is consistent with these provisions of the Kentucky Revised Statutes.

Definitions for commonly used language found in this administrative regulation can be found in 105 KAR 1:001, Definitions for KAR Title 105, which shall be in effect prior to 105 KAR 1:457; therefore, definitions contained within shall be applicable.

KRS 16.601 and 78.5534 establish survivor benefits for certain eligible beneficiaries in the event of a hazardous position employee's death resulting from an act in-line-of-duty. This administrative regulation establishes the procedures for filing and administering an application for in-line-of-duty survivor benefits, and the appeal procedures if denied.

Staff Recommendation:

The Office of Legal Services requests that the Committee review the attached materials and recommend presenting 105 KAR 1:457, In-Line-of-Duty Survivor Benefits, for filing approval to the full Board at the June 28, 2023, meeting.

List of attached materials:

1. 105 KAR 1:457, Periodic Disability Review.
2. Form 6010, "Estimated Retirement Allowance";
3. Form 6025, "Direct Rollover/Direct Payment Election Form for a Member, beneficiary, or Alternate Payee Regarding an Eligible Rollover Distribution";
4. Form 6110, "Affidavit of Authorization to Receive Funds on Behalf of Minor";
5. Form 6130, "Authorization for Deposit of Retirement Payment";
6. Form 6135, "Request for Payment by Check";

7. Form 6458, “Designation of Dependent Child for In Line of Duty/Duty-Related”;
8. Form 6800, “Application for Duty Related/In Line of Duty Survivor Benefits”;
9. Form 6810, “Certification of Beneficiary”; and
10. Form 8030, “Employer Job Description”.

FINANCE AND ADMINISTRATION CABINET

Kentucky Public Pensions Authority

(New Administrative Regulation)

105 KAR 1:457. In-Line-of-Duty Survivor Benefits.

RELATES TO: KRS 13B.010-13B.170, 16.578, 16.601, 61.505, 61.615, 61.640, 61.665, 61.691, 78.545, 78.5518, 78.5528, 78.5532, 78.5534

STATUTORY AUTHORITY: KRS 61.505(1)(g)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 61.505(1)(g) authorizes the Kentucky Public Pensions Authority to promulgate administrative regulations on behalf of the Kentucky Retirement Systems and the County Employees Retirement System that are consistent with KRS 16.505 to 16.652, 61.510 to 61.705, and 78.510 to 78.852. KRS 16.601 and 78.5534 establish survivor benefits for certain eligible beneficiaries in the event of a hazardous position employee's death resulting from an act in-line-of-duty. This administrative regulation establishes the procedures for filing and administering an application for in-line-of-duty survivor benefits, and the appeal procedures if denied.

Section 1. Definitions.

(1) "Contingent eligible beneficiary" means an individual that meets the requirements to be an eligible beneficiary, except that he or she is superseded by a different eligible beneficiary.

(2) “Eligible beneficiary” means an individual who meets the eligibility qualifications for in-line-of-duty survivor benefits as provided by KRS 16.601(1)-(3) and 78.5534(1)-(3).

(3) “Submit” means the required form, documentation, report, or payment has been received by the retirement office via mail, fax, electronic mail, the Employer Self Service Website, or other mode specifically detailed in this administrative regulation.

Section 2. Use of Third-party Vendors.

(1) The agency may contract with third-party vendors to act on its behalf throughout the in-line-of-duty survivor benefit application and review process.

(2) The agency may utilize independent, licensed physicians provided by third-party vendors to serve as medical examiners pursuant to KRS 61.665 and 78.545. Third-party vendors may provide additional persons to fulfill non-physician roles throughout the in-line-of-duty survivor benefit application process.

(3) Third-party vendors may act on behalf of the agency and the systems with all the rights and responsibilities therein.

Section 3. Requesting in-line-of-duty survivor benefits.

(1)(a) In-line-of-duty survivor benefits pursuant to KRS 16.601 and 78.5534 may be requested for an eligible beneficiary by filing a written request that shall include:

1. Member’s name and date of birth or other identifying number;

2. Member’s date of death;

3. Employer’s name and circumstance surrounding the member’s death; and

4. Name, relationship, and contact information for the person making the request.

(b) If the agency becomes aware of a hazardous position employee’s death potentially resulting from an act in-line-of-duty, the agency or the agency’s third-party vendor may

notify an eligible beneficiary, or his or her parent or legal guardian, of his or her ability to file a written request for in-line-of-duty survivor benefits.

(2) If the agency becomes aware of a hazardous position employee's death potentially resulting from an act in-line-of-duty, the agency or the agency's third-party vendor shall notify the member's employer of the following requirements that shall be completed and submitted to the agency or the agency's third-party vendor:

(a) A copy of the deceased member's death certificate;

(b) The employer's death investigation report;

(c) A detailed position description or a valid Form 8030, Employer Job Description; and

(d) A valid Form 6800, Application for Duty Related/In-Line-of-Duty Survivor Benefits, certified by the deceased member's immediate supervisor and agency head.

(3) If requested by the agency or the agency's third-party vendor, the eligible beneficiary or his or her parent or legal guardian, or the employer, shall respectively file or submit any additional information including additional medical information, autopsy or other medical records, information about the member's job duties and accommodations, documentation relating to Workers' Compensation claims, and police or other crime reports.

Section 4. Determining eligibility for in-line-of-duty survivor benefits.

(1) Once all forms and documentation required by Section 3 of this administrative regulation are on file, the agency or the agency's third-party vender shall evaluate and make a determination regarding in-line-of-duty survivor benefits pursuant to KRS 16.601

and 78.5534. The agency or the agency's third-party vendor shall notify the eligible beneficiary, or his or her parent or legal guardian, of the findings.

(2) If in-line-of-duty survivor benefits are approved, the eligible beneficiary, or his or her parent or legal guardian, shall complete all requirements in Sections (6)-(8) of this administrative regulation prior to any benefits beginning.

(3)(a) If in-line-of-duty survivor benefits are denied, the eligible beneficiary, or his or her parent or legal guardian, shall have until the end of day one hundred eighty (180) calendar days from the date the notice of denial is mailed to complete one of the following:

1. Submit additional supporting information in accordance with Section 5 of this administrative regulation; or

2. Request a formal hearing to appeal the decision in accordance with Section 10 of this administrative regulation.

(b) Denial of in-line-of-duty survivor benefits shall not affect any other benefits to which an eligible beneficiary may be entitled.

Section 5. Additional supporting information after denial.

(1) If the eligible beneficiary, or his or her parent or legal guardian, files additional supporting information including additional medical information, autopsy or other medical records, information about the member's job duties and accommodations, documentation relating to Workers' Compensation claims, police or other crime reports, or other required documentation by the end of day one hundred eighty (180) calendar days from the date of a denial of in-line-of-duty survivor benefits, the agency or the agency's third-party vendor shall review and evaluate the additional supporting information.

(2) Once the agency or the agency's third-party vendor completes the evaluation of the additional supporting information provided in accordance with subsection (1) of this section, the agency or the agency's third-party vendor shall make a determination and notify the eligible beneficiary of the findings.

(a) If the application for in-line-of-duty survivor benefits is approved, the eligible beneficiary, or his or her parent or legal guardian, shall complete all requirements in Sections (6)-(8) of this administrative regulation prior to any benefits beginning.

(b) If the findings indicate the additional supporting information filed failed to provide enough evidence to approve in-line-of-duty survivor benefits, the in-line-of-duty survivor benefits shall be denied, and the eligible beneficiary, or his or her parent or legal guardian, shall have one hundred eighty (180) calendar days from the date the notification of denial is mailed to request a formal hearing to appeal the findings in accordance with Section 10 of this administrative regulation.

Section 6. Election of benefits.

(1) An eligible beneficiary shall not be eligible for in-line-of-duty survivor benefits if he or she elects benefits under other provisions of KRS 16.505-16.652 and 78.510-78.852 or withdraws or rolls over the deceased member's accumulated account balance, except an eligible beneficiary who elects to receive benefits under KRS 16.578(2)(a) or (b), 61.640(2)(a) or (b), or 78.5532(2)(a) or (b) while the application for in-line-of-duty survivor benefits is processed.

(a) If the member dies prior to the first day of the month in which the member would have been eligible to receive his or her first retirement allowance, the eligible beneficiary

shall be entitled to death before retirement benefits pursuant to KRS 16.578, 61.542 (1)-(3), 61.640, 78.545, 78.5532 and 105 KAR 1:180.

(b) If the member dies on or after the first day of the month in which the member would have been eligible to receive his or her first retirement allowance, the eligible beneficiary shall be entitled to death after retirement benefits pursuant to KRS 61.542(4)-(5), KRS 61.630, 78.545, and 105 KAR 1:240.

(2) If the eligible beneficiary elects to receive benefits under KRS 16.578(2)(a) or (b), 61.640(2)(a) or (b), or 78.5532(2)(a) or (b) while the application for in-line-of-duty survivor benefits is processed and the eligible beneficiary is approved for in-line-of-duty survivor benefits, the agency shall determine what is owed to the eligible beneficiary in accordance with KRS 16.601(6) and 78.5534(6).

Section 7. Requirements to receive in-line-of-duty survivor benefits.

(1) The agency shall provide the eligible beneficiary, or his or her parent or legal guardian, with a Form 6810, Certification of Beneficiary. The eligible beneficiary, or his or her parent or legal guardian, shall complete and file a valid Form 6810.

(2) The agency shall provide the eligible beneficiary, or his or her parent or legal guardian, the monthly payment options available on the Form 6010, Estimated Retirement Allowance. The eligible beneficiary, or his or her parent or legal guardian, shall complete and file a valid Form 6010.

(3)(a) If the eligible beneficiary, or his or her parent or legal guardian, elects the in-line-of-duty survivor benefit option that includes the one-time payment of $10,000, the eligible beneficiary, or his or her parent or legal guardian, shall file a completed Form

6025, Direct Rollover/Direct Payment Election Form for a Member, or a Spouse Beneficiary of an Eligible Rollover Distribution.

(b) If the eligible beneficiary, or his or her parent or legal guardian, intends to have the funds rolled over directly into an IRA or other qualified plan, the eligible beneficiary, or his or her parent or legal guardian, shall have the trustee or institution relevant to the IRA or other qualified plan complete the applicable section of the Form 6025 certifying that the rollover will be accepted.

(4) If an eligible beneficiary is a spouse, he or she shall file the following documents:

(a) A copy of his or her certificate of marriage to the member; and

(b) Proof of his or her date of birth by filing one of the following:

1. Age record of the Social Security Administration;

2. Immigration and naturalization service records;

3. Birth certificate;

4. Military discharge;

5. U.S. passport:

6. Driver's license issued by the Commonwealth of Kentucky; or

7. Other reliable proof of date of birth that may be used by the courts to verify date of birth.

(5) If an eligible beneficiary is a dependent child, each dependent child, or his or her parent or legal guardian, shall file the following documents:

(a) A valid Form 6458, Designation of Dependent Child for In Line of Duty/Duty-Related;

(b) If a dependent child is under the age of eighteen (18), a valid Form 6110, Affidavit of Authorization to Receive Funds on Behalf of Minor. If the dependent child has a court appointed guardian or conservator and the court appointed guardian or conservator completed the Form 6110, the guardian or conservator shall file a copy of the court order appointing the guardian or conservator.

(c) If the dependent child is age eighteen (18) or over and a full-time student, verification of full-time student status;

(d) If the dependent child is age eighteen (18) or over and receives federal Social Security disability benefits, a copy of the most recent statement issued by the Social Security Administration indicating the dependent child is disabled; or if the dependent child is being claimed as a qualifying child for tax purposes due to the dependent child's total and permanent disability, a copy of the deceased member’s most recent tax return showing the dependent child was totally and permanently disabled for tax purposes, or duly appointed order of the court specifying the dependent child is a disabled dependent child of the deceased member; and

(e)1. A copy of the dependent child’s birth certificate; or

2. A final order or decree of adoption which shall include his or her date of birth or other reliable proof of date of birth that may be used by the courts to verify date of birth.

(6) If an eligible beneficiary is a dependent as provided by KRS 16.601(3) and 78.5534(3), each dependent, or each dependent’s parent or legal guardian, shall file the following:

(a) A copy of the deceased member's most recent tax return showing the dependent was the deceased member's qualifying dependent for tax purposes, or duly appointed order of the court specifying the dependent is a dependent of the deceased member.

(b) If the dependent is under the age of eighteen (18), a valid Form 6110, Affidavit of Authorization to Receive Funds on Behalf of Minor. If the dependent has a court appointed guardian or conservator and the court appointed guardian or conservator completed the Form 6110, the guardian or conservator shall file a copy of the court order appointing the guardian or conservator; and

(c) Proof of his or her date of birth by filing one of the following:

1. Age record of the Social Security Administration;

2. Immigration and naturalization service records;

3. Birth certificate;

4. Military discharge;

5. U.S. passport:

6. Driver's license issued by the Commonwealth of Kentucky; or

7. Other reliable proof of date of birth that may be used by the courts to verify date of birth.

(7) A contingent eligible beneficiary shall be required to provide proof that he or she is the eligible beneficiary. The agency shall not process benefits for a contingent eligible beneficiary unless the following requirements are met:

(a) If the agency identified eligible beneficiary is deceased, a copy of his or her death certificate shall be on file; or

(b) If the agency identified eligible beneficiary was divorced from the deceased member, a copy of the divorce decree shall be on file.

Section 8. Distribution of payments.

(1) The agency shall not disburse payment for in-line-of-duty survivor benefits until the eligible beneficiary, or his or her parent or legal guardian, has completed the requirements of either subsection (2) or (3) of this section.

(2)(a) To receive in-line-of-duty survivor benefits the eligible beneficiary, or his or her parent or legal guardian, shall authorize direct deposit to an account in a financial institution, in the following way:

1. File a valid Form 6130, Authorization for Deposit of Retirement Payment; and

2. Provide the information and authorizations required for the electronic transfer of funds from the State Treasurer's Office to the designated financial institution, including any authorizations or information needed from the financial institution.

(b) At any time while receiving a monthly benefit, the eligible beneficiary, or his or her parent or legal guardian, may change the designated institution by completing and filing a new valid Form 6130, Authorization for Deposit of Retirement Payment, or by updating the authorization for deposit of retirement payments on the Member Self-Service Website maintained by the agency.

(3) If the eligible beneficiary, or his or her parent or legal guardian, does not currently have an account with a financial institution, or his or her financial institution does not participate in the electronic funds transfer program, the eligible beneficiary, or his or her parent or guardian, may receive in-line-of-duty survivor benefits by check. For the eligible

beneficiary to receive payment by check, the eligible beneficiary, or his or her parent or legal guardian, shall complete and file a valid Form 6135, Request for Payment by Check.

(4) The most recently filed valid Form 6130, Authorization for Deposit of Retirement Payment, authorization for deposit of retirement payments on the Member Self-Service Website, or valid Form 6135, Request for Payment by Check, shall control the payment or electronic transfer designation of the eligible beneficiary's in-line-of-duty survivor benefits.

(5)(a) Once an eligible beneficiary is approved for in-line-of-duty survivor benefits and has completed and filed all forms and documentation required by Sections (3)-(8) of this administrative regulation, in-line-of-duty survivor benefits shall be paid retroactive to the month following the month of the member's date of death.

(b) Any increases provided under KRS 61.691 and 78.5518 shall be applied in determining the ongoing monthly payments and total retroactive payments owed to the eligible beneficiaries.

Section 9. Requirements for dependent children after in-line-of-duty survivor benefits begin.

(1) Once an eligible dependent child begins receiving in-line-of-duty survivor benefits, each dependent child, or his or her parent or legal guardian, shall be required to:

(a) Notify the agency of the death or marriage of the dependent child;

(b) If applicable, notify the agency if the dependent child ceases to be a full-time student;

(c) If applicable, notify the agency if the dependent child's disability status changes; and

(d) If applicable, file a copy of the dependent child's verification of full-time student status with the agency for each semester of study within thirty (30) calendar days following the start, and within thirty (30) calendar days following the end of each semester.

(2) Each dependent child, or his or her parent or legal guardian, shall be responsible for repaying any benefits overpaid to the dependent child, or his or her parent or legal guardian, due to the failure of the dependent child, or his or her parent or legal guardian, to provide the information required by this section.

Section 10. Right to appeal.

(1) A request for a formal hearing to appeal a denial of in-line-of-duty survivor benefits may be made by an eligible beneficiary, or his or her parent or legal guardian, in accordance with KRS 61.665 and 78.545. The request shall be made by filing a written request containing a short and plain statement of the issues being appealed.

(2) The hearing shall be conducted in accordance with KRS Chapter 13B.010-13B.170.

(3) The hearing officer presiding over an administrative hearing shall review the administrative record and any records introduced at the administrative hearing.

(a) The determination of other state and federal agencies’ approval of benefits, including the Kentucky Department of Workers' Claims and the Social Security Administration, may support a final determination if accompanied by underlying objective medical evidence or vocational evidence.

(b) Written statements from medical providers within the administrative record shall not themselves be objective medical evidence, but may be relied upon if accompanied by, and reviewed in concert with, other supporting objective medical evidence.

(4) The final determination shall not be bound by factual or legal findings of other state or federal agencies. The final determination shall be based on objective medical evidence and vocational records, including objective medical evidence and vocational records contained within or that accompany a determination by another state or federal agency.

(5) Once a final determination is issued, the person who filed the appeal shall be notified of the final order of the Administrative Appeals Committee (AAC) in accordance with KRS 61.615(3)(g) and 78.5528(3)(g).

Section 11. Incorporation by reference.

(1) The following material is incorporated by reference:

(a) Form 6010, “Estimated Retirement Allowance”, updated April 2021;

(b) Form 6025, “Direct Rollover/Direct Payment Election Form for a Member, beneficiary, or Alternate Payee Regarding an Eligible Rollover Distribution”, updated June 2023;

(c) Form 6110, “Affidavit of Authorization to Receive Funds on Behalf of Minor”, updated June 2023;

(d) Form 6130, “Authorization for Deposit of Retirement Payment”, updated June 2023;

(e) Form 6135, “Request for Payment by Check”, updated June 2023;

(f) Form 6458, “Designation of Dependent Child for In Line of Duty/Duty-Related”, updated June 2023;

(g) Form 6800, “Application for Duty Related/In Line of Duty Survivor Benefits”, updated June 2023;

(h) Form 6810, “Certification of Beneficiary”, updated June 2023; and

(i) Form 8030, “Employer Job Description”, updated June 2023.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Public Pensions Authority, 1260 Louisville Road, Frankfort, Kentucky 40601, Monday through Friday, from 8:00 a.m. to 4:30 p.m. This material is also available on the agency’s Website at kyret.ky.gov.

APPROVED:

_____ _____

DAVID L. EAGER, DATE
EXECUTIVE DIRECTOR
KENTUCKY PUBLIC PENSIONS AUTHORITY

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing to allow for public comment on this administrative regulation shall be held on Tuesday, September 26, 2023, at 2:00 p.m. Eastern Time at the Kentucky Public Pensions Authority (KPPA), 1270 Louisville Road, Frankfort, Kentucky 40601. Individuals interested in presenting a public comment at this hearing shall notify this agency in writing no later than five workdays prior to the hearing of their intent to attend. If no notification of intent to attend the hearing was received by that date, the hearing may be cancelled. A transcript of the public hearing will not be made unless a written request for a transcript is made.

If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until September 30, 2023. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

KPPA shall file a response with the Regulations Compiler to any public comments received, whether at the public comment hearing or in writing, via a Statement of Consideration no later than the 15th day of the month following the end of the public comment period, or upon filing a written request for extension, no later than the 15th day of the second month following the end of the public comment period.

CONTACT PERSON: Jessica Beaubien, Policy Specialist, Kentucky Public Pensions Authority, 1260 Louisville Road, Frankfort, KY 40601, email Legal.Non-Advocacy@kyret.ky.gov, telephone (502) 696-8800 ext. 8570, facsimile (502) 696-8615.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Regulation number: 105 KAR 1:457
Contact person: Jessica Beaubien
Phone number: 502-696-8800 ext. 8570
Email: Legal.Non-Advocacy@kyret.ky.gov

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the procedures and requirements for applying or reapplying for in-line-of-duty survivor benefits and for administratively appealing a denial of an application for in-line-of-duty survivor benefits.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the procedures and requirements for applying or reapplying for in-line-of-duty survivor benefits and for administratively appealing a denial of an application for in-line-of-duty survivor benefits.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the authorizing statute by establishing the procedures and requirements for applying or reapplying for in-line-of-duty survivor benefits and for administratively appealing a denial of an application for in-line-of-duty survivor benefits in accordance with KRS 16.601 and 78.5534.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the statutes by establishing the procedures and requirements for applying or reapplying for in-line-of-duty survivor benefits and for administratively appealing a denial of an application for in-line-of-duty survivor benefits in accordance with KRS 16.601and 78.5534.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: The Kentucky Public Pensions Authority, the Kentucky Retirement Systems, and the County Employees Retirement System, and the members and beneficiaries of the Kentucky Retirement Systems and the County Employees Retirement System. Number of individuals is unknown. Number of businesses, organizations, or state and local governments affected

is three (3): the Kentucky Public Pensions Authority, the Kentucky Retirement Systems, and the County Employees Retirement System.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: This amendment should not substantially alter the actions that the Kentucky Public Pensions Authority, the Kentucky Retirement Systems, and the County Employees Retirement System will have to take to comply with this regulation.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): This regulation should not cost any additional funds.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The amendment allows the Kentucky Public Pensions Authority, the Kentucky Retirement Systems, and the County Employees Retirement System to conform with KRS 61.505 to 61.705, 16.510 to 16.652, and 78.520 to 78.852, particularly the in-line-of-duty survivor benefit application process as well as the process for administratively appealing the denial of in-line-of-duty survivor benefit applications.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The costs associated with the implementation of this administrative regulation should be negligible.

(b) On a continuing basis: The costs associated with the implementation of this administrative regulation should be negligible.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Administrative expenses of the Kentucky Public Pensions Authority are paid from the Retirement Allowance Account (trust and agency funds).

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: There is no increase in fees or funding required.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees or directly or indirectly increase any fees.

(9) TIERING: Is tiering applied? (Explain why or why not) Tiering is not applied. All members are subject to the same processes and procedures.

FISCAL NOTE

Regulation number: 105 KAR 1:457
Contact person: Jessica Beaubien
Phone number: 502-696-8800 ext. 8570
Email: Legal.Non-Advocacy@kyret.ky.gov

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Kentucky Public Pensions Authority, the Kentucky Retirement Systems, and the County Employees Retirement System.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 61.505(1)(g).

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? The cost to Kentucky Public Pensions Authority should be negligible.

(d) How much will it cost to administer this program for subsequent years? The cost to Kentucky Public Pensions Authority should be negligible.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): None

Expenditures (+/-): Unknown

Other Explanation:

(4) Estimate the effect of this administrative regulation on the expenditures and cost savings of regulated entities for the first full year the administrative regulation is to be in effect.

(a) How much cost savings will this administrative regulation generate for the regulated entities for the first year? None

(b) How much cost savings will this administrative regulation generate for the regulated entities for subsequent years? None

(c) How much will it cost the regulated entities for the first year? Unknown

(d) How much will it cost the regulated entities for subsequent years? Unknown

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Cost Savings (+/-): None

Expenditures (+/-): Unknown

Other Explanation:

(5) Explain whether this administrative regulation will have a major economic impact, as defined below. "Major economic impact" means an overall negative or adverse economic impact from an administrative regulation of five hundred thousand dollars ($500,000) or more on state or local government or regulated entities, in aggregate, as determined by the promulgating administrative bodies. [KRS 13A.010(13)]. This administrative regulation will not have a major economic impact.

SUMMARY OF MATERIAL INCORPORATED BY REFERENCE

Form 6010, Estimated Retirement Allowance, is a one (1) page form that provides eligible beneficiaries with his or her estimated retirement allowance payment options from which he or she must elect prior to receiving benefits.

Form 6025, Direct Rollover/Direct Payment Election Form for a Member, beneficiary, or Alternate Payee Regarding an Eligible Rollover Distribution, is a two (2) page form that eligible beneficiaries use to elect direct rollover or direct payment when he or she has elected the benefit option that includes the one-time payment of $10,000.

Form 6110, Affidavit of Authorization to Receive Funds on Behalf of Minor, is a one (1) page form used by the parent or guardian of an eligible beneficiary of in-line-of-duty survivor benefits who is under the age of eighteen (18) that allows the parent or guardian to receive funds for the eligible beneficiary.

Form 6130, Authorization for Deposit of Retirement Payment, is a two (2) page form that eligible beneficiaries of in-line-of-duty survivor benefits use to authorize direct deposit of his or her benefits to a financial institution.

Form 6135, Request for Payment by Check, is a one (1) page form that eligible beneficiaries of in-line-of-duty survivor benefits use to receive payment of his or her benefits by check.

Form 6458, Designation of Dependent Child for In Line of Duty/Duty-Related, is a one (1) page form that must be completed by the eligible beneficiary, or his or her parent or guardian, to attest that the dependent child identified is in fact a dependent child prior to receiving any payment of in-line-of-duty survivor benefits.

Form 6800, Application for Duty Related/In Line of Duty Survivor Benefits, is a one (1) page form completed by the deceased member’s employer to certify the date, time, location, and description of the incident to determine if the incident qualifies as an act-in-line-of-duty and eligibility of in-line-of-duty survivor benefits.

Form 6810, Certification of Beneficiary, is a one (1) page form completed by eligible beneficiaries to certify his or her eligibility as a beneficiary.

Form 8030, Employer Job Description, is a three (3) page form completed by the employer to provide KPPA with details of the deceased member’s job duties and requirements in order for KPPA to determine eligibility for in-line-of-duty survivor benefits.

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*6010/ [redacted]

[redacted]

FORM 6010

FORM 6010 ESTIMATED RETIREMENT ALLOWANCE

Retirement Date: [redacted]
Retirement Plan: [redacted]
Retirement Type: [redacted]

Member Information

[redacted]

Member Date of Birth: [redacted]
Member ID: [redacted]

Beneficiary Information

Beneficiary: [redacted]
Beneficiary Date of Birth: [redacted]

Please Select ONE payment option by checking one box below	Payment to member while living	Payment to beneficiary after member's death
☐ BASIC	[redacted]	[redacted]
☐ LIFE WITH 10 YEARS CERTAIN		
☐ LIFE WITH 15 YEARS CERTAIN		
☐ LIFE WITH 20 YEARS CERTAIN		
☐ SURVIVORSHIP 100%		
☐ SURVIVORSHIP 66 2/3%		
☐ SURVIVORSHIP 50%		
☐ POP-UP		
☐ 10 YEARS CERTAIN		

☐ I REJECT ALL MONTHLY PAYMENT OPTIONS AND REQUEST A(n) ACTUARIAL REFUND OF APPROXIMATELY [redacted] I AM ALSO FORFEITING ANY HEALTH INSURANCE AND DEATH BENEFITS PROVIDED BY THE KENTUCKY PUBLIC PENSIONS AUTHORITY.

NOTE: If you select the actuarial refund or lump sum refund you must also complete and return the enclosed Form 6025, Direct Rollover/Direct Payment Election Form. The Form 6025 is located in the Special Tax Notice.

This estimate was calculated using an early retirement percentage of 100.00%.

Certification

I CERTIFY THAT I HAVE SELECTED THE OPTION OF MY CHOICE. I REALIZE THAT AFTER THE FIRST DAY OF THE MONTH IN WHICH I RECEIVE MY FIRST RETIREMENT CHECK, I WILL NOT HAVE THE RIGHT TO CHANGE MY PAYMENT OPTION OR MY BENEFICIARY.

Signature of Recipient: _____ Date: _____

Signature of Spouse: _____ Date: _____

Witnessed by: _____ Date: _____

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Print Form

Form 6025
Revised 04/2021

Direct Rollover/Direct Payment Election Form for a Member, Beneficiary, or Alternate Payee Regarding an Eligible Rollover Distribution

Required Information: Failure to complete all items and sign this form could delay the processing of your lump sum/ monthly benefit.

Recipient Information			
Member Name:		Member ID:	
If you are not the member, please provide your name and Social Security Number (SSN) below.			
Name:		SSN:	
Address:	City:	State:	Zip Code:
Is this a new address? ◯ Yes ◯ No			

This form must be completed if you are electing to receive an "eligible rollover distribution." **Failure to complete this form could delay the processing of your lump sum/monthly benefit.** If you are the member, the following payment options are "eligible rollover distributions": Actuarial Refund, Partial Lump Sum, and Refund of Contributions. If you are a beneficiary, the following payment options are "eligible rollover distributions": Actuarial Refund, Refund of Contributions, $5,000 Death Benefit, $10,000 Lump-Sum Survivor Benefit payment pursuant to KRS 16.601 and 78.5534, and 60 Months Certain.

Please read the enclosed SPECIAL TAX NOTICE REGARDING PLAN PAYMENTS. **If you have questions about the SPECIAL TAX NOTICE, please contact a qualified tax advisor. Kentucky Public Pensions Authority employees are not qualified to answer questions concerning your tax status or the effects of the federal tax laws and regulations**. After you have read the SPECIAL TAX NOTICE, you must complete the following form to certify that you have read the SPECIAL TAX NOTICE and to make your selections with regard to treatment of your payment.

Distribution of Payment Election: If you are unsure about the information to provide in this section, please contact our office for assistance from a counselor to avoid possible delays in processing your benefits.

I elect a complete distribution of my payment as follows:

If your distribution will include a taxable portion, you must select one option from this column.	If your distribution will include a non-taxable portion, you must select one option from this column.
Taxable Portion (Monies have not yet been taxed)	Non-Taxable Portion (Monies have already been taxed)
☐ Direct Rollover	☐ Direct Rollover
☐ Paid Directly to me (less 20% withholding*)	☐ Paid Directly to me
☐ Partial Rollover in the amount of $_____, balance (less 20% withholding*) paid to me.	☐ Partial Rollover in the amount of $_____, balance paid to me.

Complete page 2 only if you select a rollover

I certify that I have read the enclosed SPECIAL TAX NOTICE REGARDING PLAN PAYMENTS and have selected the distribution option indicated above. I understand that my payment will not be processed until this form is completed and returned to the retirement office. I understand that I have a right to at least 30 days from my receipt of the SPECIAL TAX NOTICE in which to make my decision regarding receipt or rollover of these funds, and by signing and returning this form, I waive my right to the full 30-day period. I understand that if I elect to receive any or all of the taxable portion directly, 20% of the taxable portion paid to me will be withheld for my federal income taxes.* I understand that no tax will be withheld if I have the entire taxable portion rolled over. If I elect to have any or all of the payment rolled over, I will have the Trustee receiving the rollover complete the back of this form. I understand that in the case of monthly payments, my selection will remain in effect for each monthly payment until I change my election.

I hereby certify that the information completed on this form is true and accurate. I acknowledge that I have full understanding that any person who provides a false statement, report, or representation to a governmental entity such as KPPA is subject to the penalty of perjury in accordance with KRS 523.010, et seq. I further acknowledge that if I knowingly submit or cause to be submitted a false or fraudulent claim for the payment or receipt of benefit, I (personally) may be liable for restitution of the benefits for which I or a minor recipient was not eligible to receive, civil payments, legal fees, and costs.

Signature: _____ Date: _____

***If you are a nonresident alien, the mandatory withholding rate is 30% of 20%, unless a tax treaty exemption applies.**

Recipient Information

Member Name:	Member ID:

Direct Rollover Information: To be completed by Trustee of IRA or eligible plan receiving rollover. Please complete both sections if the distribution will include a taxable portion and a non-taxable portion.

Taxable Portion *(Monies have not yet been taxed)*

- ☐ Traditional Individual Retirement Account/Annuity*
- ☐ Roth Individual Retirement Account/Annuity*
- ☐ 401(a) Qualified Plan, 403(a) Qualified Annuity, 403(b) Annuity Contract, or 457(b) Governmental Plan*
- ☐ SIMPLE IRA that has been established for at least two (2) years*

Make check payable to: _____

Account number (if applicable): _____

Send check to: _____

As agent for the above named plan, I certify that the above plan is an eligible plan and will accept the rollover for the benefit of the distributee of pre-tax dollars that would otherwise be taxable upon distribution.

Trustee/Agent Signature: _____ Phone: _____

Title: _____ Date: _____

Non-Taxable Portion *(Monies have already been taxed)*

- ☐ Traditional Individual Retirement Account/Annuity*
- ☐ Roth Individual Retirement Account/Annuity*
- ☐ 401(a) Qualified Plan or 403(b) Annuity Contract*

Make check payable to: _____

Account number (if applicable): _____

Send check to: _____

As agent for the above named plan, I certify that the above plan is an eligible plan and will accept the rollover for the benefit of the distributee of post-tax dollars, and will separately account for such post-tax dollars, in the case of a 401(a) qualified plan or a 403(b) annuity contract.

Trustee/Agent Signature: _____ Phone: _____

Title: _____ Date: _____

*** If you are a non-spouse beneficiary, you may only rollover your payment to an "inherited" individual retirement account/annuity. The "inherited" IRA may be either a traditional IRA or a Roth IRA.**

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Print Form

Form 6110
Revised 06/2023

Affidavit of Authorization to Receive Funds on Behalf of Minor

Member Information Please provide your Member ID or Social Security Number in the Member ID box below.			
Member Name:		Member ID:	
Address:	City:	State:	Zip Code:
Phone: ☐ Home ☐ Mobile ☐ Work	Email:		

Minor Recipient Information	
Minor Name:	Minor's Social Security Number:

Comes the Affiant, and states as follows:

My name is: _____ My address is: _____
City: _____ State: _____ Zip Code: _____

I understand that the Minor Recipient named above is the beneficiary of certain benefits payable from the Kentucky Public Pensions Authority on the account of the above named Member.

I am legally authorized to receive the benefits on behalf of the Minor Recipient in my capacity as (check one):

☐ Natural/custodial parent of the Minor Recipient

☐ Court-appointed guardian, conservator, or other representative of the Minor Recipient (attach a copy of the court authorization)

I further state that no divorce decree, termination of parental rights, adoption, or any other legal process of any type, whether voluntary or involuntary, affects or inhibits my legal authority to receive funds on behalf of the Minor Recipient. I further acknowledge that if an order or other process affects my authority to receive the funds on behalf of the Minor Recipient, it will be my duty to notify the Kentucky Public Pensions Authority promptly and provide a full and complete copy of any documents affecting my authority to receive funds on behalf of the Minor Recipient.

I hereby certify that the information completed on this form is true and accurate. I acknowledge that I have full understanding that any person who provides a false statement, report, or representation to a governmental entity such as KPPA is subject to the penalty of perjury in accordance with KRS 523.010, et seq. I further acknowledge that if I knowingly submit or cause to be submitted a false or fraudulent claim for the payment or receipt of benefit, I (personally) may be liable for restitution of the benefits for which the Minor Recipient was not eligible to receive, civil payments, legal fees, and costs.

Signature: _____

Printed Name: _____

Date: _____

State of: _____

County of: _____

The foregoing instrument was acknowledged before me this _____ day of _____ , 2 _____ ,
by _____ .

_____

Notary Public

My Commission Expires: _____

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Print Form

Form 6130
Revised 04/2021

Authorization for Deposit of Retirement Payment

Recipient Information
The recipient is the person who is receiving a monthly benefit from the Kentucky Public Pensions Authority. Please provide your Member ID or Social Security Number in the Recipient ID box below.

Recipient Name:		Recipient ID:	
Address:	City:	State:	Zip Code:
Is this a new address? ◯Yes ◯No			
Phone (select type) ◯ Mobile ◯ Home ◯ Work		Email:	
If you are beneficiary of the account, please provide the member's name and Member ID below.			
Member Name:		Member ID:	

Financial Institution Information

Financial Institution Name:	Account Type: ◯ Checking ◯Savings
Depositor Account Number:	Depositor Routing Number:

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

Authorization for Direct Deposit and International Transactions:

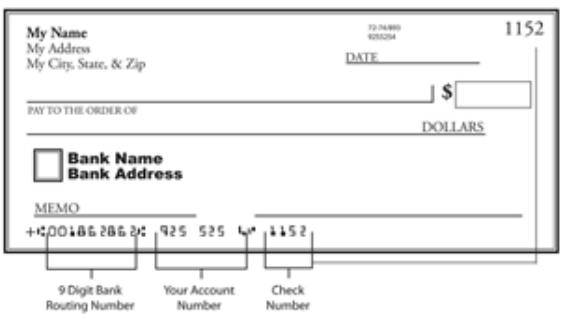
I authorize and request the Kentucky Public Pensions Authority to directly deposit the net amount of my monthly retirement payment to my account at the financial institution designated above. I have attached to this form the documentation indicated above.
I understand that failure to sign this authorization and provide one of the documents listed above will cause a delay in setting up or changing account information.

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 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 Kentucky Public Pensions Authority in writing immediately if the payment becomes subject to transfer to a foreign bank in the future.

Signature: _____ Date: _____

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



Instructions for Completing Form 6130
Authorization for Deposit of Retirement Payment

You may authorize deposit of your retirement benefit directly into your account at a financial institution by either complete this Form 6130, Authorization for Deposit of Retirement Payment, or by designating an account online through Member Self Service. Your designated financial institution account can be changed by either submitting a new Form 6130 or by updating the account information online through Member Self Service. 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). The North American Clearing House Association (NACHA) regulations require certification to identify any direct deposit payment made where the payment amount is subsequently transferred to a foreign bank account.

This form is to be used ONLY for the deposit of monthly benefit payments from the Kentucky Public Pensions Authority (KPPA). This form does not authorize withdrawals from your financial institution.

Please provide the necessary information about the financial institution. You must sign and date the authorization form. You are required to provide a VOIDED personalized check or verification from the financial institution for deposit to a checking account. For deposit to a savings account you must provide a verification from the financial institution. Your failure to sign and date the authorization form and provide the required documentation will cause a delay in setting up or changing the account information. Your monthly benefit payments will be deposited into your account at your financial institution on the 14th unless the day is a weekend or holiday, then the payment will be deposited into your account on the last business day prior to the 14th. If you are a current recipient of a monthly benefit and request a change to the account number or financial institution to which your monthly benefit is deposited, the completed form must be received at the Kentucky Public Pensions Authority' office before the 20th of the month if you wish the change to be effective with the next payment. If your form is received after the 20th of the month, the next monthly payment will be issued as a paper check, which will be mailed to your listed address; and the requested change for the direct deposit will be effective the following month. If you have additional questions regarding the change, please contact a KPPA Counselor at (800) 928-4646 or (502) 696-8800.

Once the authorization form has been processed by the Kentucky Public Pensions Authority, this authorization for deposit may be cancelled for any of the following reasons:

1. A new authorization for deposit of retirement payment form is submitted and processed at KPPA. This new Form 6130 will supersede your previous authorization form.
2. Your designated account information is updated online through Member Self Service.
3. The financial institution no longer accepts direct deposit. If your financial institution no longer accepts direct deposit, you must notify KPPA.
4. Your financial institution rejects your direct deposit indicating your account is closed. In this case, KPPA will notify you of the cancellation in advance.
5. Your monthly benefit no longer covers the cost of your health insurance premium and you must submit payment to our office for your health insurance premium.
6. Notice of your death is received at KPPA.

You may reach the Kentucky Public Pensions Authority at (800) 928-4646 or (502) 696-8800 if you have any questions. Written inquiries can be addressed to Kentucky Public Pensions Authority, 1260 Louisville Road, Frankfort, Kentucky 40601. For general information or to obtain additional forms, visit the Kentucky Public Pensions Authority' website: kyret.ky.gov.

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Print Form

Form 6135
Revised 05/2015

Request for Payment By Check

Recipient Information

The recipient is the person who is receiving the monthly benefit from the retirement system. Please provide your Member ID or Social Security Number in the Recipient ID box below.

Recipient Name:		Recipient ID:	
Address:	City:	State:	Zip Code:
Phone Number:	Is this a new address? ◯ Yes ◯ No		

Reason for Receiving Retirement Allowance by Check

◯ I do not currently have an account with a financial institution. I will contact the retirement office when I have opened an account to which my benefit may be deposited.

◯ My financial institution does not participate in the Electronic Funds Transfer (EFT) program. The following must be completed by your financial institution:

Name of Institution: _____ Phone: _____

This recipient has an account in our institution, but we do not currently participate in the EFT program.

Authorized Signature of
Financial Institution Officer: _____ Title: _____

Certification

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. I understand that I must contact the retirement office if the above situation changes so that I may have my retirement allowance electronically transferred to my account. The retirement office may require me to verify the above information.

Signature: _____ Date: _____

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Form 6458
6/2023

Designation of Dependent Child for In Line of Duty/Duty-Related

Deceased Member's Information: Please provide the Member ID or Social Security number in the Member ID box below.			
Member Name:		Member ID:	
Address:	City:	State:	Zip Code:

Parent/Guardian Information: Please provide your Member ID or Social Security number in the Member ID box below.			
Parent/Guardian Name:		Member ID:	
Address:	City:	State:	Zip Code:

Dependent Information			
Dependent Name:	Dependent Social Security Number:	Date of Birth:	
Address:	City:	State:	Zip Code:
Has this child "been determined to be eligible for federal Social Security disability benefits" or "been claimed as a qualifying child for tax purposes due to the child's total and permanent disability? ☐ Yes ☐ No If YES, please submit a current statement of disability issued by the Social Security Administration, or the most recent tax return showing the child is claimed due to the child's total and permanent disability.			
Complete the following if the dependent child is over the age of eighteen, unmarried, and a full-time student.			
Dependent's School:		Phone Number:	
School Address:	City:	State:	Zip Code:

Certification

I,_____, do hereby state that I am the parent or guardian of the dependent child as defined by KRS 16.505(17) and 78.510(49), or I am the dependent child over the age of 18, of the deceased member.

I understand and agree that I will:

- Notify the Kentucky Public Pensions Authority when the dependent child designated above marries, ceases to be a full-time student, or otherwise ceases to qualify as a dependent child as defined by KRS 16.505(17) and 78.510(49).
- Immediately provide written notification to the Kentucky Public Pensions Authority as soon as the person designated above no longer qualifies as a dependent child as defined by KRS 16.505(17) and 78.510(49).
- Be responsible for repayment of any benefits paid to the person designated above if said person is not a dependent child as defined by KRS 16.505(17) and 78.510(49).

I hereby certify that the information completed on this form is true and accurate. I acknowledge that I have full understanding that any person who provides a false statement, report, or representation to a governmental entity such as KPPA is subject to the penalty of perjury in accordance with KRS 523.010, et seq. I further acknowledge that if I knowingly submit or cause to be submitted a false or fraudulent claim for the payment or receipt of benefit, I (personally) may be liable for restitution of the benefits for which the person designated above was not eligible to receive, civil payments, legal fees, and costs.

Signature: _____ Date: _____

Notary Certificate

State of: _____

County of: _____

The foregoing instrument was acknowledged before me this ____ of _____ 20 ____ , by

_____.

My Commission Expires: _____

Notary Public: _____

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Print Form

Form 6800
Revised 04/2021

Application for Duty Related/In Line of Duty Death Benefits

Deceased Member Information			
Member Name:		Member ID:	
Birthdate:	Marital Status: ☐ Married ☐ Single ☐ Divorced		
Date of Death:	Termination Date (if different than date of death):		
Employer Information			
Agency Name:	Telephone:	Fax:	
Agency Address:	City:	State:	Zip Code:

Incident Information
Please provide the requested information below and submit the following documents with this form:

(1) Member's death certificate (2) Incident investigation report (3) Police report (if applicable) (4) Employee's job description

Date of Incident:	Time of Incident:
Location of Incident:	
Is there a police report documenting this incident? ☐ Yes ☐ No If yes, please submit a copy with this form.	
Description of Incident:	

Certification

I certify that I have full knowledge of the penalty in KRS 523.100 related to the falsification of records and the information provided on this form is true and accurate.

Printed Name of Member's Immediate Supervisor: _____

Signature of Member's Immediate Supervisor: _____ Date: _____

Approved by:

Printed Name of Agency Head: _____

Signature of Agency Head: _____ Date: _____

When all sections have been completed, please return this form to:
Kentucky Public Pensions Authority
1260 Louisville Road
Frankfort, KY 40601

Kentucky Public Pensions Authority
1260 Louisville Rd. • Frankfort KY 40601
Phone: (502) 696-8800 • Fax: (502) 696-8822 • kyret.ky.gov

Print Form

Form 6810
Revised 06/2023

Certification of Beneficiary

Member Information Please provide your Member ID or Social Security number in the Member ID box below.	
Member Name: [redacted]	Member ID: [redacted]

Beneficiary Information If an individual is the beneficiary, please complete the following section. If an Estate or Trust is beneficiary skip to the Estate or Trust Information section.			
Name: [redacted]		Social Security Number:	
Telephone Number:		Date of Birth: exampleexampleexample	
Address:	City:	State:	Zip Code:
Relationship to member:			
Authority of Signature: ◯ Beneficiary ◯ Guardian ◯ Power of Attorney			
Signature:		Date:	
Witness:		Date:	

Estate or Trust Information Complete this section only if the Estate or Trust is beneficiary.			
Name of Representative(s):		Telephone Number:	
Address:	City:	State:	Zip Code:
Federal Tax ID No. (Provide the Estate EIN or Trust ID if applicable):			
Fiduciary Authority : ◯ Administrator / Executor / Personal Representative ◯ Trustee (Trust only)			
Fiduciary's Signature:		Date:	
Witness:		Date:	
Fiduciary's Signature: (for multiple executors only)		Date:	
Witness:		Date:	

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Employer Instructions for Member Filing for Disability

Revised 11/2021

IMPORTANT: Failure to return the required information within 5 business days may cause a delay in the member's monthly benefit and health insurance.

A disability retirement application has been initiated through Kentucky Public Pensions Authority.

For members who apply for disability retirement, KRS 61.665(2)(a) requires a complete description of the member's job duties and requirements and requires that the member make a request for reasonable accommodations as provided for in 42 U.S.C. sec. 12111(9) and 29 C.F.R. Part 1630 through the American with Disabilities Act (ADA).

Examples of reasonable accommodations may include:

- Making existing facilities accessible to individuals with disabilities
- Job restructuring
- Part-time or modified work schedules
- Reassignment to a vacant position
- Retraining
- Purchase of assistive equipment

If the individual has terminated employment with your agency or did not request accommodations, you should outline what accommodations **were made** or **could have been made** on the enclosed Form 8030.

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Print Form

Form 8030
Revised 11/2021

Employer Job Description

Employee Information

Employee Name:	Member ID:
Job Title:	Agency:

Job Description

Describe the employee's job duties performed as of the last day worked: _____

_____

_____

_____ Total hours in a workday. _____ Sitting hours in a day. _____ Standing/walking hours in a day.

Does the employee have the ability to alternate between sitting and standing/walking? ☐ Yes ☐ No

Physical effort required: (check appropriate boxes)	Never	Seldom/ Rare	Occasional (up to 1/3 of work day)	Frequent (1/3 to 2/3 of work day)	Repetitive (2/3 or more of work day)
Handle/Finger/Feel:	☐	☐	☐	☐	☐
Reach/Push/Pull:	☐	☐	☐	☐	☐
Bend/Stoop/Crouch:	☐	☐	☐	☐	☐
Kneel/Crawl:	☐	☐	☐	☐	☐
Climb/Balance:	☐	☐	☐	☐	☐
Lift/Carry (frequency):	☐	☐	☐	☐	☐
☐ Up to 10 lbs.	☐	☐	☐	☐	☐
☐ Up to 20 lbs.	☐	☐	☐	☐	☐
☐ Up to 50 lbs.	☐	☐	☐	☐	☐
☐ Up to 100 lbs.	☐	☐	☐	☐	☐
☐ Over 100 lbs.	☐	☐	☐	☐	☐

Identify the items or tools the employee was required to lift and/or carry in performing the essential job duties (include the weight, distance, and frequency of the lifting and/or carrying): _____

_____

_____

Identify the heaviest item and weight lifted on a frequent basis (1/3 to 2/3 of workday): _____

Identify the heaviest item and weight lifted without assistance: _____

Please identify any physical effort requirements for the employee to perform his or her job duties as of the last day worked. (Check appropriate boxes)

☐ The employee was required to handle, grab, or grasp items or tools. (file, ledger, hammer, wrench, pot/pan, mop/bucket)
☐ The employee was required to finger, feel, or sort items or tools. (computer keyboard, typewriter, calculator, pen/pencil)
☐ The employee was required to use machinery that used hand and/or foot controls. (backhoe, school bus)
☐ The employee was required to use vibratory equipment, machinery, or tools. (jackhammer, floor buffer, lawnmower)
☐ The employee was required to reach overhead, and in all other directions.
☐ The employee was required to use stairs or ramps.
☐ The employee was required to use ladders or scaffolding.
☐ The employee was exposed to environmental elements such as extreme heat, extreme cold, or extreme wetness/dampness.
☐ The employee was exposed to excessive noise, fumes, odors, gases, or dust.

Please make any remarks concerning the physical effort requirements for the employee to perform his or her job duties as of the last day worked: _____

_____

Accommodations: Examples of reasonable accommodations may include making existing facilities accessible to individuals with disabilities, job restructuring, part-time or modified work schedules, reassignment to a vacant position, retraining, or purchase of assistive equipment. If the individual has terminated employment with your agency or did not request accommodations, you should outline what accommodations were made or could have been made.

Did the employee request accommodations, assistance, or help to perform the essential job duties? ☐ Yes ☐ No

IF YES, please attach a copy of the request. Please attach any written response by the agency to the employee for request for accommodations. Please attach a statement describing the accommodations, assistance, or help that was offered or attempted to allow the employee to perform the essential job duties.

IF NO, please describe the accommodations, assistance, or help that was reasonably available to allow the employee to perform the essential job duties. _____

_____

_____

_____

Did the employee have any machines, tools, or equipment available to assist in performing job duties, such as a handcart, desk mover, special chair, headphones, keyboard, tape recorder, or other? _____

_____

Did the employee have assistance available from co-workers? _____

Where accommodations were made available, requested, or implemented, was the job as accommodated offered to the employee indefinitely?: ☐ Yes ☐ No

Attach additional pages if necessary.

Personnel Issues:

Was the employee injured on the job? ☐ Yes ☐ No If YES, please attach a copy of the incident report.

Is the employee currently receiving Workers' Compensation benefits? ☐ Yes ☐ No

If YES, please provide the Workers' Compensation insurance carrier name and address assisting with this claim.

Insurance Carrier Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Please indicate the employee's current personnel status:

☐ Termination ☐ Sick Leave Without Pay ☐ Still on Payroll ☐ Other _____

If the employee has terminated or is utilizing a leave without pay status, please provide date and attach a copy of the personnel form:

_____

If the employee is not still on the payroll, please verify the last day of paid employment: _____

Supervisor Name: _____ Title: _____

Address/Phone: _____

IMPORTANT: FAILURE TO RETURN THE REQUIRED INFORMATION WITHIN 5 BUSINESS DAYS MAY CAUSE A DELAY IN THE MEMBER'S MONTHLY BENEFIT AND HEALTH INSURANCE.
For members who apply for disability retirement through Kentucky Public Pensions Authority, KRS 61.665(2)(a) requires a complete job description of the member's job duties and requirements and requires that the member make a request for reasonable accommodations as provided for in 42 U.S.C. sec. 12111(9) and 29 C..F.R. Part 1630 through the American with Disabilities Act (ADA).

Certification

I hereby certify that the above information is correct and accurately describes the job duties that the employee had as of the last day worked. I understand that the Kentucky Public Pensions Authority or the employee may request that I testify at an administrative hearing as to the matters described herein.

Agency Representative Printed Name: _____

Agency Representative Title: _____

Agency Representative Signature: _____ Date: _____