



Disability Retirement Election Application

888 CalPERS (or 888-225 7377) TTY (877) 249 7442

Employer Information

Check if this is an employer originated application
Employer must fill out and sign Section 12 on the last page of this application

Application Type

Disability Retirement Industrial Disability Retirement
 Service Pending Disability Retirement Service Pending Industrial Disability Retirement

Section 1

Information About You

Please provide your name as it appears on the Social Security card
Name of Member (First Name Middle Initial Last Name) SHELDON K SCARDER Social Security Number or CalPERS ID [Redacted]
Address [Redacted]
City [Redacted] State [Redacted] Zip [Redacted] County [Redacted]
Please display all dates in this order month/day/year
Birth [Redacted] Gender Male Female Home Phone [Redacted] Alternate Phone SAME

Section 2

Information About Your Retirement

Please refer to the detailed instructions in this publication
Last Day on Payroll (mm/dd/yyyy) 3/1/12 Retirement Effective Date (mm/dd/yyyy) 2/29/15 ^{E.O.B.}
Employer CA HIGHWAY PATROL Position Title ASSISTANT CHIEF

Please do not abbreviate your employer's name or position title

Other California Public Retirement Systems

Are you a member of a California public retirement system other than CalPERS? No Yes provide

Name of System

Are you currently working with the other system? No Yes

Date of Retirement with Other System (mm/dd/yyyy)

2013-1-16-11-21

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CALPERS
DEC 17

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Put your name and Social Security number or CalPERS ID at the top of every page

SHELON KYLIE SEAROSE [Redacted]
Your Name Social Security Number or CalPERS ID

Section 3

Disability Information

Please complete all the questions below. If you need additional space, attach separate sheets and be sure to include your name and Social Security number or CalPERS ID on all sheets.

What is your specific disability? LARDO AND STRESS (2 STRESS). HYPERTENSIVE AND STRESS DECREASE IN HEARTH (HIGH BLOOD PRESSURE, ETC), ANXIETY, HYPOCHONDRIA, ARRHYTHMIA
When did the disability occur? (mm/dd/yyyy) 1997 (APPROX)

How did the disability occur? SURGICALLY, DEMYELINATING DISEASE.

Local Safety members should not complete

Section 3

What are your limitations/precautions due to your injury or illness? CONSTANT PAIN IN HANDS,

BLURRED VISION, BLACK-OUT SPELLS, RESTRICTED SEVER VISION, CHEST PAINS, STRESS, LOSS OF BALANCE, ^{HEAVY} BLOOD PRESSURE
How has your injury or illness affected your ability to perform your job? UNABLE TO FOCUS,

RETINAL TISSUE, BILATERAL DEFECTS IN PERIPHERY VISION

EMPLOYEE OFF-OUT (NO WORK) FROM RESEARCHING 12/20/12
BLACK OUT SPELLS

Are you currently working in any capacity? No Yes (PARTIALLY CAN PHYSICALLY PUT OFF DUTY 12/20/12 - 5/1/13.)

If yes, what is your employment status? Full time Part time

Job Duties SEE ATTACHS.

Other information you would like to provide UNDER CONTRACT WITH OF

CALIFORNIA & MICHIGAN.

If you indicated a third party liability CalPERS will require additional information

Did a third party cause your injury? No Yes (if yes CalPERS has a potential right of subrogation)

Section 4

Treating Physician Detail

Local Safety members should not complete

Section 4

What is the complete name and address of your treating physician(s)?

ROBERT | CRAMER (JESS CRAMER) | [Redacted]
First Name Last Name Your Medical Record Number

6051 N. 7TH ST
Address

FRESNO | CA | 93710 | U.S.
City State ZIP Country

GEN PHYSICIAN | | (559) 436-5265
Specialty Secondary Specialty Phone Number

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Put your name and Social Security number or CalPERS ID at the top of every page

SHELDON KYLE SCARBOR
Your Name

[REDACTED]
Social Security Number or CalPERS ID

Section 5

Select Your Retirement Payment Option and Beneficiary

Select only one payment option
Option 1 Option 2
Option 2W Option 3
Option 3W the Unmodified Allowance Option or one of the Option 4 types

By filling out this section you are electing your Retirement Payment Option and designating your beneficiary. Once you select a payment option you cannot change to another option. Along with your option selection you must complete at least one of the beneficiary designations in Sections 5a-5d. If you choose the Unmodified Allowance Option you do not need to specify a beneficiary. Please refer to the detailed instructions in this publication for more information.

- Option 1 - To complete this option you must also fill out Section 5d *Balance of Contributions Beneficiary(ies)*
- Option 2 - To complete this option you must also fill out Section 5a *Individual Lifetime Beneficiary*
- Option 2W - To complete this option you must also fill out Section 5a *Individual Lifetime Beneficiary*
- Option 3 - To complete this option you must also fill out Section 5a *Individual Lifetime Beneficiary*
- Option 3W - To complete this option you must also fill out Section 5a *Individual Lifetime Beneficiary*
- Unmodified Allowance Option - If you select this option there is no return of your member contributions and no monthly benefits payable upon your death - except the Survivor Continuance benefit if applicable. There is no beneficiary designation for this option.

These options apply to Option 4 Individual Lifetime Beneficiary only

- Option 4 Individual Lifetime Beneficiary - If you select this option you must also select one of the following Individual Lifetime Beneficiary options below:
 - Option 2W & Option 1 Combined - To complete this option you must also fill out Section 5a *Individual Lifetime Beneficiary* and Section 5d *Balance of Contributions Beneficiary(ies)*
 - Option 3W & Option 1 Combined - To complete this option you must also fill out Section 5a *Individual Lifetime Beneficiary* and Section 5d *Balance of Contributions Beneficiary(ies)*
 - Specific Dollar Amount to Beneficiary \$ _____ - To complete this option you must also fill out Section 5a *Individual Lifetime Beneficiary* Dollars
 - Specific Percentage to Beneficiary _____ % - To complete this option you must also fill out Section 5a *Individual Lifetime Beneficiary* Percent
 - Reduced Allowance by \$ _____ or _____ % through _____
Dollars Percent Date (month/day/yyyy)
To complete this option you must also fill out Section 5a *Individual Lifetime Beneficiary*
 - Reduced Allowance upon death of retiree or beneficiary \$ _____ reduction amount
Dollars
To complete this option you must also fill out Section 5a *Individual Lifetime Beneficiary*

This option applies to Option 4 Multiple Lifetime Beneficiaries only

- Option 4 Multiple Lifetime Beneficiaries - To complete this option choose you must also fill out Section 5b *Option 4 Multiple Lifetime Beneficiaries*

These options apply to Option 4 Court Ordered Community Property only

- Option 4 Court Ordered Community Property - If you select this option you must also complete Section 5c *Court Ordered CP Beneficiary* and select one of the following Court Ordered Option 4 Community Property options:
 - Option 4/Unmodified - There is no additional beneficiary designation for this option
 - Option 4/1 - To complete this option you must also fill out Section 5d *Balance of Contributions Beneficiary(ies)*
 - Option 4/2W - To complete this option you must also fill out Section 5a *Individual Lifetime Beneficiary*
 - Option 4/3W - To complete this option you must also fill out Section 5a *Individual Lifetime Beneficiary*

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Put your name and Social Security number or CalPERS ID at the top of every page

SARAH K SCARPER _____
Your Name Social Security Number or CalPERS ID

Section 5a

Option 2, 2W, 3, 3W or 4 Individual Lifetime Beneficiary

Designate one beneficiary and provide all of that person's information including full name

Complete this section only if you chose either Option 2, 2W, 3, 3W or Option 4 Individual Lifetime Beneficiary or Option 4/2W or 4/3W Court Ordered Community Property

Name (First Name Middle Initial Last Name) _____ Social Security Number or CalPERS ID _____

Birth Date (mm/dd/yyyy) _____ Gender Male Female Relationship to You _____

Address _____

City _____ State _____ ZIP _____ Country _____

Section 5b

Option 4 Multiple Lifetime Beneficiaries

If you want your beneficiaries to receive an equal share of your benefits do not specify a dollar or percentage of benefit

Complete this section only if you selected Option 4 Multiple Lifetime Beneficiaries

If you are married or are in a registered domestic partnership your spouse or domestic partner may be entitled to the community property interest in the option allowance payable to your designated beneficiary according to law

Name (First Name Middle Initial Last Name) _____ Social Security Number or CalPERS ID _____

Birth Date (mm/dd/yyyy) _____ Gender Male Female Relationship to You _____ Dollar/Percent of Benefit _____

Address _____

City _____ State _____ ZIP _____ Country _____

Name (First Name Middle Initial Last Name) _____ Social Security Number or CalPERS ID _____

Birth Date (mm/dd/yyyy) _____ Gender Male Female Relationship to You _____ Dollar/Percent of Benefit _____

Address _____

City _____ State _____ ZIP _____ Country _____

Name (First Name Middle Initial Last Name) _____ Social Security Number or CalPERS ID _____

Birth Date (mm/dd/yyyy) _____ Gender Male Female Relationship to You _____ Dollar/Percent of Benefit _____

Address _____

City _____ State _____ ZIP _____ Country _____

Section 5c

Court Ordered Option 4 Community Property Beneficiary

List only the Option 4 beneficiary that is required by your court order

Complete this section only if you selected Option 4 Court Ordered Community Property

Name (First Name Middle Initial Last Name) _____ Social Security Number or CalPERS ID _____

Birth Date (mm/dd/yyyy) _____ Gender Male Female Relationship to You _____

Address _____

City _____ State _____ ZIP _____ Country _____

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Put your name and Social Security number or CalPERS ID at the top of every page

Your Name SHELDON K SCARIS-92 Social Security Number or CalPERS ID [REDACTED]

Section 5d

Option 1 Balance of Contributions Beneficiary(ies)

Designate up to three beneficiaries here. If you want to designate more than three beneficiaries see the information in this publication on completing the *Post Retirement Lump Sum Beneficiary Designation* form.

If you are married or are in a registered domestic partnership your spouse or domestic partner may be entitled to the community property interest in the option allowance payable to your designated beneficiary according to law.

Complete this section only if you selected Option 1, Option 4 2W/1 or 3W/1 combined. You may change this beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. Please refer to the detailed instructions in this publication for more information.

Name (First Name Middle Initial Last Name) _____ Social Security Number or CalPERS ID _____

Birth Date (mm/dd/yyyy) _____ Gender Male Female Relationship to You _____

Address _____

City _____ State _____ ZIP _____ Country _____

Name (First Name Middle Initial Last Name) _____ Social Security Number or CalPERS ID _____

Birth Date (mm/dd/yyyy) _____ Gender Male Female Relationship to You _____

Address _____

City _____ State _____ ZIP _____ Country _____

Name (First Name Middle Initial Last Name) _____ Social Security Number or CalPERS ID _____

Birth Date (mm/dd/yyyy) _____ Gender Male Female Relationship to You _____

Address _____

City _____ State _____ ZIP _____ Country _____

Section 6

Retired Death Benefit

All Applicants must complete this section.

Designate your beneficiary to receive your lump sum Retired Death Benefit.

This section designates the person who will receive your lump sum Retired Death Benefit. You may change this beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. Please refer to the detailed instructions in this publication for more information.

Name (First Name Middle Initial Last Name) _____ Social Security Number or CalPERS ID _____

Birth Date (mm/dd/yyyy) _____ Gender Male Female Relationship to You WIFE

Address _____

City _____ State _____ ZIP _____ Country _____

Section 6 continues on page 6

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Put your name and Social Security number or CalPERS ID at the top of every page

Your Name SHELDON K. SARBEL Social Security Number or CalPERS ID [REDACTED]

Section 6, continued

Retired Death Benefit

All Applicants must complete this section

Designate your beneficiary to receive your lump sum Retired Death Benefit

Name (First Name Middle Initial Last Name) Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) Gender Male Female Relationship to You

Address

City State ZIP Country

Name (First Name Middle Initial Last Name) Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) Gender Male Female Relationship to You

Address

City State ZIP Country

Section 7

Survivor Continuance

Please answer all five questions and complete the information in each section where you answered Yes

Please refer to the detailed instructions in this publication for more information

1 Will you be married on your disability retirement date? No Yes provide

Name of Spouse (First Name Middle Initial Last Name) Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) Gender Male Female Date of Marriage (mm/dd/yyyy)

Address

City State ZIP Country

2 Will you be registered with the California Secretary of State as being in a domestic partnership on or before your disability retirement date? No Yes provide

Name of Domestic Partner (First Name Middle Initial Last Name) Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) Gender Male Female Date of Registered Partnership (mm/dd/yyyy)

Address

City State ZIP Country

3 Do you have any natural or adopted unmarried children under age 18? No Yes provide

Name of Child (First Name Middle Initial Last Name) Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy) Gender Male Female

Address

City State ZIP Country

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Put your name and Social Security number or CalPERS ID at the top of every page

Your Name SHELDON N SCARFEL Social Security Number or CalPERS ID [REDACTED]

Section 7, continued

Survivor Continuance

Name of Child (First Name Middle Initial Last Name) _____ Social Security Number or CalPERS ID _____

Birth Date (mm/dd/yyyy) _____ Gender Male Female

Address _____

City _____ State _____ ZIP _____ Country _____

4 Do you have any unmarried children who were disabled prior to their 18th birthday and who are still disabled?
 No Yes provide

Name of Child (First Name Middle Initial Last Name) _____ Social Security Number or CalPERS ID _____

Birth Date (mm/dd/yyyy) _____ Gender Male Female

Address _____

City _____ State _____ ZIP _____ Country _____

Name of Child (First Name Middle Initial Last Name) _____ Social Security Number or CalPERS ID _____

Birth Date (mm/dd/yyyy) _____ Gender Male Female

Address _____

City _____ State _____ ZIP _____ Country _____

5 Are your parents dependent upon you for one half of their support? No Yes provide

Name of Parent (First Name Middle Initial Last Name) _____ Social Security Number or CalPERS ID _____

Birth Date (mm/dd/yyyy) _____ Gender Male Female

Address _____

City _____ State _____ ZIP _____ Country _____

Name of Parent (First Name Middle Initial Last Name) _____ Social Security Number or CalPERS ID _____

Birth Date (mm/dd/yyyy) _____ Gender Male Female

Address _____

City _____ State _____ ZIP _____ Country _____

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Put your name and Social Security number or CalPERS ID at the top of every page

SHELDON K. SCARPER
 Your Name

[REDACTED]
 Social Security Number or CalPERS ID

Section 8

Workers' Compensation Detail

Local safety members should not complete Section 8

Do you have any worker's compensation claims? Yes No

05856912 1597 CA
Claim Number(s) Date of Injury (mm/dd/yyyy) Body Part(s)

SCIF
Workers' Compensation Claim

PEGGY EGGERS
Name of Adjuster First Last

(916) 589-3066
Phone Number Fax Email

PO BOX 1250 977
Address of Workers' Compensation Claim Center

SHELDON SCARPER CA 95682
City State ZIP

Section 9

Tax Withholding Election

Please choose one only

Federal Income Tax information Please refer to the detailed instructions in this publication for more information

- Do not withhold federal income tax
- Withhold federal income tax in the amount of \$ _____ per month
Dollars
- Withhold federal income tax based on the tax tables for
 - A married individual with 2 tax withholding exemptions
Number
 - A single individual with _____ tax withholding exemptions
Number
 In addition to the amount withheld based on the tax tables withhold \$ _____ per month
Dollars

Please choose one only
 State withholding is optional for out of state residents

State Income Tax information Please refer to the detailed instructions in this publication for more information

- Do not withhold State of California income tax
- Withhold State of California income tax in the amount of \$ _____ per month
Dollars
- Withhold State of California income tax based on the tax tables for
 - A married individual with 2 tax withholding exemptions
Number
 - A single individual with _____ tax withholding exemptions
Number
 In addition to the amount withheld based on the tax tables withhold \$ _____ per month
Dollars
- Withhold State of California income tax in the amount of 10 percent of the federal income tax withholding amount

Section 10

CalPERS Health Coverage

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If you are currently enrolled in your own right for CalPERS health benefits you can continue your health enrollment into retirement with no break in coverage

If you do not want health coverage you must cancel retiree health coverage by declining coverage below. You may be eligible to enroll in health coverage during the next Open Enrollment period

I decline continuation of my CalPERS health coverage into retirement

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Put your name and Social Security number or CalPERS ID at the top of every page

SHELDON K SCARBUR
Your Name
[Redacted]
Social Security Number or CalPERS ID

Section 11

Member Signature and Notary

This section must be completed or your application will be returned

I certify under the penalty of perjury that the information submitted hereon is true and correct to the best of my knowledge. I understand to cancel this application or to change the elected option or beneficiary I must notify CalPERS before the mailing of my first full monthly retirement allowance check.

Your signature and your spouse's or domestic partner's signature must be notarized by a notary public or witnessed by a CalPERS representative.

I understand that if I am married or in a registered domestic partnership but do not name my spouse or partner as beneficiary they may still be entitled to a community property share of the Option 1 (lump sum return of contributions benefit or a share of the monthly option death benefit allowance. Their community property interest is 50% of the benefit based on the contributions or service credit earned for the period of CalPERS service during which we were married or in a registered partnership. My non spouse or non partner designated beneficiary will receive the portion of the lump sum Option 1 benefit or monthly option allowance that is not payable to my spouse or domestic partner. I understand that my spouse or domestic partner will have the right to disclaim entitlement to their community property interest in the death benefit at the time the benefit becomes payable if they so desire.

If your spouse's or domestic partner's signature is not available see instructions in this publication on completing the Justification for Absence of Signature form.

More detailed information on this section is available in this publication.

Are you legally married or do you have a legal domestic partner? Yes No

If yes, your spouse or domestic partner must sign this election.

If no, please indicate: Never Married/or in Partnership Divorced/Annulled Widowed Or Termination of Domestic Partnership

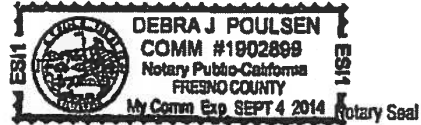
[Signature]
Your Signature
2/27/2013
Date (mm/dd/yyyy)

[Signature]
Your Spouse's or Domestic Partner's Signature
02-27-2013
Date (mm/dd/yyyy)

State of California County of FRESNO

On 2-27-13 before me, Debra J. Poulsen a Notary
Name of Notary/Witness

[Redacted] who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies) and that by his/her/their signature(s) on the instrument the person(s) or the entity upon behalf of which the person(s) acted executed the instrument. I certify under Penalty of Perjury under the laws of the State of California that the foregoing paragraph is true and correct.



Witness my hand and official seal or authorized CalPERS representative signature

[Signature]
Signature of Notary or CalPERS Representative
Notary
Position Title
02-27-2013
Date (mm/dd/yyyy)

Debra J. Poulsen
Print Name
CalPERS Office (if applicable)

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Put your name and Social Security number or CalPERS ID at the top of every page

SHELDON K SCARBOR _____
Your Name Social Security Number or CalPERS ID

Section 12

Employer-Originated Application

To be completed if the employer is submitting the application on behalf of the member

Is employee working in any capacity? No Yes Full time Part time

Signature of Employer

Print Name of Employer

Position Title of Employer

Phone Number

Date (mm/dd/yyyy)

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Mail to: **CalPERS Benefit Services Division • PO Box 942711 Sacramento California 94229 2711**