P.O. Box 942715 Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377) | Fax: (800) 959-6545
www.calpers.ca.gov

California Public Employees' Retirement System

Instructions for Completing the Report of Separation for Death Request for Payroll Information

We have been notified that this member has passed away. In order for us to be able to pay survivor benefits we require completion of the attached form. Your cooperation in immediately providing the following information is an important part of ensuring the accurate and prompt payment of death benefits.

PART I. EFFECTIVE DATES REGARDING SEPARATION

Separation Date: Provide the last day that the member was considered an employee of your organization.

Last Day on Pay Status: Provide the date that the member was last on pay status with your organization. This would be the last day the member was subject to CalPERS contributions, whether they were deducted from their earnings or not. Please explain any difference between date of separation and last day on pay status, or, if member was on leave of absence, please provide the dates of absence.

Time Base: Check mark the correct time base for the member.

Required Hours: If part-time, also indicate required hours. **Required hours are needed for the entire period of employment.**

Reason for Separation: Please check mark the reason member separated from employment. If other, please provide a detailed explanation.

PART II. UNUSED SICK AND EDUCATIONAL LEAVE AT TIME OF SEPARATION

Please enter the total number of days or hours of unused sick leave and educational leave credits (G.C. Section 20963.1) the employee had at the time of separation and check the box identifying hours or days.

PART III. HEALTH AND DENTAL INSURANCE

To be completed only by State, Local, and School agencies which contract for health and/or dental coverage under the Public Employees' Hospital and Medical Care Act. Please attach copies of current health and dental enrollment forms. Failure to provide this information may result in lapse of coverage for eligible annuitants. Coverage Group code will need to be provided for Local and School agency employees ONLY.

PART IV. CERTIFICATION OF EMPLOYER

Certify that the provided information is accurate and complete. Please include your direct telephone number and extension.

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PLEASE COMPLETE AND FAX TO (916) 795-3988 AS SOON AS POSSIBLE

REPORT OF SEPARATION FOR DEATH – REQUEST FOR PAYROLL INFORMATION

Business Partner CID:	Business Partner:	
Member Name:	SSN:xxx-xx- CID:	Date Of Death:

PART I. EFFECTIVE DATES REGARDING SEPARATION

Separation Date: _____ (Note: The last day the member was considered an employee)	**Last Day on Pay Status:** _____ (Note: This date cannot be after the DOD or Separation date)	**Reason for Separation**: ☐ Death ☐ Illness ☐ Contract/Assignment Ended ☐ Other (please explain): _____
Time Base: ☐ Fulltime ☐ Part-time ☐ Indeterminate ☐ Intermittent ☐ Substitute ☐ Seasonal ☐ Worked as needed ☐ Other: _____		**Required Hours for entire membership period: (For part-time members, only)** Example: 11/10/2008 – 2/14/2012- 6hrs/day From/To: _____ # of hours: _____ From/To: _____ # of hours: _____

PART II. UNUSED SICK AND EDUCATIONAL LEAVE AT TIME OF SEPARATION

TOTAL UNUSED SICK LEAVE: _____ DAYS ☐ HOURS ☐

BALANCE OF EDUCATIONAL LEAVE CREDITS: _____ DAYS ☐ HOURS ☐

PART III. HEALTH AND DENTAL INSURANCE

Type of Coverage	Plan Name	Name(s) of Covered Dependents	Coverage Group (If Applicable)
HEALTH INSURANCE			
DENTAL INSURANCE			

PART IV. CERTIFICATION OF EMPLOYER

_____

Printed Name Title Direct Telephone Number and Extension

_____

Signature of Payroll Officer Date