

# DISABILITY RETIREMENT INFORMATION FORM

IMPERIAL COUNTY EMPLOYEES' RETIREMENT SYSTEM

1221 W.State Street  
El Centro, CA 92243

Member's Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_

Member's Social Security Number: \_\_\_\_\_

Member's Date of Birth: \_\_\_\_\_

Salary used for Retirement calculation

Do you want your last year worked used as your one year's highest salary?

YES  NO

If your answer is NO indicate what year you want us to use.

\_\_\_\_\_

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## Beneficiary Information

Beneficiary's Name: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

Beneficiary's Date of Birth: \_\_\_\_\_

Beneficiary's Address: \_\_\_\_\_

\_\_\_\_\_

Name(s) of all Minor Children  
Of Member (whether or not  
Designated as Beneficiary)

Date of Birth

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_