Office of the New York State Comptroller

NYSLRS

New York State and Local Retirement System

110 State Street, Albany, New York 12244-0001

**Please type or print clearly
in blue or black ink**

Received Date

SURVIVOR'S BENEFIT PROGRAM
Notification of Employee's Death

RS 6358
(Rev. 10/18)

Deceased NYSLRS ID

**Deceased
Social Security Number** [last 4 digits]

XXX-XX-

Retirement System [check one]

Employees' Retirement System (ERS) ☐

Police and Fire' Retirement System (PFRS) ☐

INSTRUCTIONS: Parts A and B are to be completed by the employer. If an answer is 'None' or 'Unknown', please indicate. This form should be forwarded to the attention of the Survivor's Benefit Program at the address above whenever an employee dies. This will enable us to avoid needless delay in initiating payment to the beneficiary.

PART A:

1. Name of Employee: (First, Middle Initial, Last)	2. Date of Birth:	3. Date of Death:

4. Date of Appointment:	5. Title:	6. Negotiating Unit:	7. Agency Code:

8. Current Payroll Item No.:	9. Name of Retirement System:	10. Ret./Registration Number:

11. Last Day on Payroll Receiving Salary: (Not date lump sum payment was processed)

12. Check Appropriate Boxes:

A – Non M/C

☐ Employee on Payroll on date of death and for 90 of the 120 days immediately preceding death

☐ Employee not on payroll on day of death but on payroll for 90 of the 120 days immediately preceding death

☐ Employee died following return to payroll from authorized leave without pay and had at least one year of State service

☐ Employee died while on authorized leave without pay, was not otherwise gainfully employed while on leave and had been on the payroll (Check A or B below):

A ☐ within six months prior to death and had at least one year of service.
OR
B ☐ within one year prior to death and had at least five years of service since date of last entry or re-entry into State service.

☐ Check if there is a possibility of accidental death benefit by Retirement System.

B- M/C

☐ Employee on payroll on day of death and for 30 of the last 60 days immediately preceding death.

☐ Employee not on payroll on day of death but on payroll for 30 of the 60 days immediately preceding death,

☐ Employee died following return to payroll from authorized leave without pay and had at least one year of State service.

☐ Employee died while on authorized leave without pay, was not otherwise gainfully employed while on leave and had been on the payroll as an M/C employee (Check A or B below):

A ☐ within six months prior to death and had at least five years of M/C service.
OR
B ☐ within one year prior to death and had at least five years of M/C service.

☐ Check if there is a possibility of accidental death benefit by Retirement System.

IMPORTANT – You must complete other side

13. Original Form RS 6357 (Non-Member Employee Designation of Beneficiary) must be attached if employee is not a retirement system member. If the RS 6357 is not on file, check box below and complete information requested. In addition, a copy of the employee's work history must be attached if employee is not a member of either the NYS Employees' Retirement System or the Police and Fire Retirement System.

☐ RS 6357 is not on file. Name and address of next of kin listed below:

_____

_____

_____

PART B – RATE OF COMPENSATION:

1. Check the appropriate box and enter requested salary and work schedule information.

If employee was NOT employed on an annual salary basis in a full-time year round position, enter the number of hours, days and weeks per year he/she would have worked during the twelve months immediately preceding his/her last day on the payroll if he/she had rendered continuous service during such period, worked the number of hours per week and weeks per year normally and regularly required of employee holding the same position. Salary rate is rate as of last day on payroll prior to death.

a. ☐ Employee worked in a full-time, year-round position and was paid on an annual salary basis. His/Her annual rate of compensation was _____ + Inconvenience Pay_____ + Location Pay _____ + Preshift Briefing _____ = _____ Total Annual Salary.

b. ☐ Employee was paid on an annual salary basis but was employed in a part-time position. The employee worked _____ hours per week _____ weeks per year. His/Her annual rate of compensation was _____.

c. ☐ Employee was paid on a per diem basis at _____ per day. He/She worked _____ hours per week, _____ days per week, _____ weeks per year. His/Her annual rate of compensation was_____.

d. ☐ Employee was paid on an hourly basis at _____ per hour. He/She worked _____ hours per week, _____ weeks per year. His/Her annual rate of compensation was _____.

e. ☐ Employee worked in a seasonal position. His/Her bi-weekly rate was_____. The employee worked_____ hours per week, _____ weeks per year. His/Her annual rate of compensation was _____.

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2. Additional Comments:

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3. I hereby certify that the above facts are shown in the records of this agency and I believe the same are true and correct.

Signature:_____ Date:_____

Agency:	Title:	Telephone Number: (Including area code)

Address: (Including Street, City, State and Zip Code:

PART C: (To be completed by Death Benefits Section of appropriate Retirement System)	PART D: (To be completed by Survivor's Benefit Program)
1. We have paid a death benefit (excluding the reserve- for- increased- take- home pay) of: $ _____.	Computation of Benefit
TO: Name:_____	☐ Ordinary Death Benefit Rate of Compensation
No & Street:_____	☐ Non M/C (1/2 Rate of Compensation) _____
City, State and Zip:_____	☐ M/C (Full Rate of Compensation) _____
Date of Birth:_____	Ordinary Death Benefit _____
Social Security Number: _____	☐ Accidental Death Benefit
2. Based on the following information:	☐ Non M/C ☐ M/C
a. ☐ Ordinary death	Survivor's Benefit Due _____
b. ☐ Accidental death	Remarks:
c. ☐ Member for less than one year	
d. ☐ Employee not a member of this system	
e. ☐ Other_____	
I hereby certify that the required Certificate of Death has been filed with this agency.	
_____ Signature	_____ Signature
_____ Retirement System	_____ Date
_____ Date	