North Carolina
Total Retirement Plans

Form 253
Reporting an Employee's Work Record In the Event of Death

Please print or type in black ink.

Section A. Employer, tell us about the employee.

FIRST NAME	MI	LAST NAME	SUFFIX	SSN (Last 4 digits)

MAILING ADDRESS	MEMBER ID

CITY	STATE	ZIP CODE	DATE OF BIRTH	TODAY'S DATE

Section B. Employer, please tell us about the employee's death, last position, and compensation.

1 Please check the retirement system that applies.

- ☐ Teachers' and State Employees' Retirement System (TSERS)
- ☐ Legislative Retirement System (LRS)
- ☐ Local Governmental Employees' Retirement System (LGERS)
- ☐ Consolidated Judicial Retirement System (CJRS)

2 What was the employee's date of death? _____

3 How was the employee employed by your unit on the date of death?

- ☐ The employee was actively contributing to the System and receiving compensation for service performed.
- ☐ The employee was receiving a benefit under the Disability Income Plan of North Carolina (DIPNC) or was in the 60-day waiting period prior to receiving benefits (applicable to TSERS employees only). If so, please attach copy of the employee's Form 701, Form 711, and the latest form 703 (if applicable).
- ☐ The employee was receiving a Workers' Compensation benefit and thus not making contributions to the System. Provided all other requirements are met, TSERS employees receiving a Workers' Compensation benefit during the short term are covered under the Death Benefit and the Survivor's Alternate Benefit.
- ☐ The employee's employment had terminated; he/she was not receiving compensation or contributing to the System.

4 What was the last date the employee actually worked or exhausted leave, whichever is later? _____

Enter compensation paid, or to be paid, for last month employee was (or will be) paid	
Month _____	
Annual Leave / Bonus Leave	
Longevity	
Supplement	
Other _____	
TOTAL	

5 What was the effective date of termination, if different from the last date paid (date **4**)? _____

6 How many days of unused sick leave did he/she have on the effective date of termination (date **5**)? _____

Please continue to the next page.

Employer Certification: I hereby certify that the information provided about the employee named in Section A is true and correct to the best of my knowledge. I certify that the unused sick leave shown reflects the amount of unused sick leave at the date of termination and is sick leave for which this member would have been paid had he/she actually chosen to exhaust sick leave. If any of this information changes, I will notify the Retirement Systems Division.

Employer Contact's Signature _____ Date_____

CONTACT FIRST NAME	CONTACT LAST NAME	POSITION TITLE	
EMPLOYER/AGENCY			UNIT NO.
E-MAIL ADDRESS		TELEPHONE NO.	FAX NO.

Please submit this form by mail to the address below or fax it to (919) 855-5800. Thank you.

N.C. Department of State Treasurer, Retirement Systems Division
3200 Atlantic Avenue, Raleigh, North Carolina 27604
1-877-NCSECURE (1-877-627-3287) toll-free
www.myncretirement.com