

State of New Jersey • Department of the Treasury  
**DIVISION OF PENSIONS AND BENEFITS**

Retirement Bureau/Quality Control  
PO Box 295 • Trenton NJ 08625-0295

**WAIVER OR RESTORATION OF PENSION ALLOWANCE**

**INSTRUCTIONS:** Check one box to indicate if you wish to waive, modify, or restore your **gross** monthly pension allowance. If requested, verify the *current* payment date, *current* payment amount, and the amount of the revised gross allowance. Provide your name, retirement number, and mailing address. Be sure to sign and date this form.

**TO: Division of Pensions and Benefits,** \_\_\_\_\_  
RETIREMENT SYSTEM

**CHECK ONE BOX ONLY**

**I hereby apply for a WAIVER** of all or a portion of the **gross** monthly pension allowance regularly due me. I acknowledge my total monthly allowance taken from my check stub dated \_\_\_\_\_ to be \$\_\_\_\_\_. (Enter the date and total allowance on your last *Statement of Allowances and Deductions*.) I request and authorize the Division of Pensions and Benefits to reduce my **gross** monthly allowance to \$\_\_\_\_\_ effective with the next available pension payment. **I understand that the gross monthly pension (before the portioned waived is applied) is the amount used to determine Medicaid eligibility.** As set forth below, I understand that the amounts waived cannot be reclaimed subsequent to the effective period of this waiver.

**I hereby apply to MODIFY** a previous waiver of the **gross** monthly pension allowance regularly due me. I acknowledge my total monthly allowance taken from my check stub dated \_\_\_\_\_ to be \$\_\_\_\_\_. (Enter the date and total allowance on your last *Statement of Allowances and Deductions*.) I request and authorize the Division of Pensions and Benefits to modify my **gross** monthly allowance to \$\_\_\_\_\_ effective with the next available pension payment.

**I hereby apply to RESTORE** the full **gross** monthly retirement or pension allowance regularly due me.

\_\_\_\_\_

I accept the reduced amount listed above as my full pension allowance until a formal change is effected with another copy of this form or my written request, and acknowledged by the retirement system. I agree that the monthly amounts so waived or modified will not continue as an obligation of the retirement system and that they cannot be reclaimed subsequent to the effective period of this waiver.

I accept any restored amount as my full pension allowance until a formal change is effected with another copy of this form and acknowledged by the retirement system.

I reserve the right to cancel or modify this request by filing another Waiver/Restoration form with the retirement system. I understand that waiver/restoration requests or cancellations must be received by the retirement system before the fifth of the month prior to the effective date of the change. I also understand that any changes will be effective only on the first day of the month.

\_\_\_\_\_  
PRINT FULL NAME

\_\_\_\_\_  
RETIREMENT NUMBER

\_\_\_\_\_  
STREET ADDRESS

\_\_\_\_\_  
CITY

\_\_\_\_\_  
STATE

\_\_\_\_\_  
ZIP CODE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE