

**MEMBERSHIP FORM**

**PLEASE PRINT**

INTERSYSTEM TRANSFER

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M F

( ) -

Name

Sex

Marital Status

Home Phone Number

Social Security Number

Birth Date

Email Address

ADDRESS:

(Street)

(Apt No.)

(City)

(State) (Zip)

Name of Spouse

Spouse's Birth Date

Number of Children Under Age 18

**PREVIOUS EMPLOYMENT:**

1. If you were previously employed in a position that was a designated position under the Corrections Officer Retirement Plan, please complete this section:

FROM

THROUGH

TITLE OF POSITION

EMPLOYER

A. \_\_\_\_\_

B. \_\_\_\_\_

2. If you indicated that you were previously employed, was a refund issued? Circle YES or NO and initial: \_\_\_\_\_

3. **A refund will NOT be issued while you are employed with the same/ or another CORP employer. Please Complete Form C1A, "Request for Transfer" and attach it to this form.**

I declare under penalty of perjury that the above information is true, correct and complete, to the best of my knowledge and belief.

DATE: \_\_\_\_\_ EMPLOYEE'S SIGNATURE: \_\_\_\_\_

**EMPLOYER ACKNOWLEDGMENT**

**EMPLOYER: (CHECK ONLY ONE)**

DEPARTMENT OF CORRECTIONS: \_\_\_\_\_ INSTITUTION OR FACILITY: \_\_\_\_\_

DEPARTMENT OF JUVENILE CORRECTIONS: \_\_\_\_\_ INSTITUTION OR FACILITY: \_\_\_\_\_

COUNTY/CITY/TOWN OF: \_\_\_\_\_

AOC (JUDICIARY, PROBATION, SURVEILLANCE, AND JUVENILE DETENTION OFFICERS): \_\_\_\_\_ COUNTY

Membership Date (with current employer)

Position or Classification

Current Annual Salary

I hereby acknowledge that this person is a full time (40+ hours) employee and the Membership Date and Position or Classification information provided above corresponds with the information in our personnel files.

Date

Telephone Number

Authorized Signature of Employer

SIGNEE TITLE: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

**PLEASE PROVIDE A COPY OF THE MEMBER'S SOCIAL SECURITY CARD**

**BENEFICIARY DESIGNATION**

NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

In the event of my death, **and after any survivor pension payable from the Plan has terminated**, I direct that my accumulated contributions arising from deductions made from my salaries, in excess of pension payments paid to me or to a survivor,

be paid to: \_\_\_\_\_  
Name(s) of **Primary** Refund Beneficiary(ies)

whose relationship(s) to me is (are): \_\_\_\_\_

if living, otherwise to: \_\_\_\_\_  
Name(s) of **Contingent** Refund Beneficiary(ies)

whose relationship(s) to me is (are): \_\_\_\_\_

and whose date(s) of birth is (are): \_\_\_\_\_

if living, otherwise to my nearest of kin as determined by the Local Retirement Board. It is agreed that if more than one primary or contingent beneficiary, as the case may be, is named, my said accumulated contributions, if payable, will be paid in equal shares to the survivors, unless otherwise noted.

DATED IN \_\_\_\_\_, ARIZONA, on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
(city or town)

\_\_\_\_\_  
SIGNATURE OF EMPLOYEE

\_\_\_\_\_  
NAME OF WITNESS-PRINTED

\_\_\_\_\_  
SIGNATURE OF WITNESS

(Witness must be persons other than beneficiaries named above)

When completed, mail to: Corrections Officer Retirement Plan  
3010 E. Camelback Rd., Suite 200  
Phoenix, Arizona 85016