

CORRECTIONS OFFICER RETIREMENT PLAN

3010 E. Camelback Rd., Suite 200
(602)255-5575 FAX (602)296-2368 www.psprs.com

FORM C6

8/11

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APPLICATION FOR A SEPARATION REFUND OR DEFERRED ANNUITY

(A.R.S. Section 38-884, et. seq.)

NAME: _____ SOCIAL SECURITY NUMBER: _____

MAILING ADDRESS: _____
(Street) (Apt. No.) (City) (State) (Zip)

PHONE NUMBER: _____ BIRTH DATE: _____

MY CORP MEMBERSHIP EMPLOYMENT WITH: _____

BEGAN ON: _____ AND TERMINATED ON: _____

I certify that I have terminated my employment; I have not been accepted for employment with any other CORP employer in a designated eligible position; I have not previously received a refund of my accumulated contributions to the CORP; the dates of membership and termination in this application and the periods of leave of absence without pay are correct; I understand the terms and requirements for the Refund Option and the Deferred Annuity Option below; and I make my election as indicated below:

REFUND OPTION

By **INITIALING** _____ **this Refund Option**, I HEREBY make application for the refund of my member contributions to the CORRECTIONS OFFICER RETIREMENT PLAN (CORP) as well as any enhanced refund as provided by law. I understand that by withdrawing my accumulated contributions, I **TERMINATE MY MEMBERSHIP AND FORFEIT ALL RIGHTS TO BENEFITS** under the CORP and my rights to rehearing and appeal. I also understand that withdrawing my accumulated contributions results in forfeiture of my service credits in the CORP (A.R.S. § 38-884). Further, I understand that if I am again employed within two years by the same employer in a position covered under CORP, these service credits may be reinstated only if a written application for reinstatement is filed with the Board of Trustees within ninety (90) days after again becoming a covered employee and my refund contribution is re-deposited within one (1) year, along with applicable interest to date of re-deposit (A.R.S. § 38-884). I understand that if I do not withdraw my contributions and I obtain employment with an employer in a CORP covered position after my termination, my service credits will be transferred to my record with my new employer. Pursuant to A.R.S. Section 38-921, I may be entitled to transfer my service credits to a new retirement system upon subsequent employment in a position not covered by CORP and that by withdrawing my contributions, I am forfeiting all of these rights. If the refund includes taxable monies, I hereby acknowledge receiving and reading the special tax notice regarding these taxable monies. **If you elect the REFUND OPTION, a refund check will be mailed to the address shown above within 20 business days after your application is filed and your final wage deduction is transmitted to this office and your termination of covered employment has been verified by your employer.**

DEFERRED ANNUITY OPTION - Effective for a member who terminates on or after September 30, 2009 according to H.B. 2326

By **INITIALING** _____ **this Deferred Annuity Option A.R.S. 38-911**, I hereby elect to leave my accumulated contributions on deposit and receive a deferred annuity commencing on or after my 62nd birthday. I understand that I may elect this deferred annuity only if I have at least ten years of credited service in the CORP. I also understand that if I die and I have accumulated contributions remaining in the CORP, those accumulated contributions will be paid to my designated refund beneficiary, if living, or to my designated contingent refund beneficiary, if living, or to my nearest living kin as selected by my local CORP board. A Deferred Annuity shall be a lifetime monthly pension actuarially equivalent to the member's accumulated contributions plus an amount paid by the employer, and shall commence on application, on or after the 62nd birthday. The Annuity is not a retirement benefit and annuitants are not entitled to receive any amount prescribed by section 38-887, 38-888, 38-904, 38-905 or 38-906. All changes of address must be reported, in writing, to the local CORP board and the Board of Trustees.

TAXABLE MONIES (All monies contributed after July 1, 2000 are taxable monies)

You must complete the information below before a refund check is issued.

By **INITIALING** _____, I understand and acknowledge the following:

1. I am aware that I have at least 30 days to decide whether I want to elect a direct rollover or to elect a cash distribution of my taxable monies and I am electing to waive this 30 day waiting period.
2. I have completed the Lump Sum Distribution Election Form that prescribes certain tax consequences regarding the above taxable monies.
3. I have received and read the special tax notice regarding these taxable monies and understand the tax consequences explained in the notice and election form.

If this application form is not witnessed or initialed, or if the Lump Sum Distribution Election form is not completed, it will be returned which will cause a delay in the processing of any enhanced portion of your refund.

If you divorced during your employment, provide our office with a copy of your Divorce Decree or Domestic Relations Order. Note: A.R.S. §§ 38-860, 38-910, 38-822 states that if you have been involved in a divorce, the System/Plan is not liable for any benefits you receive. You are considered trustee to the funds and will be the sole party against with whom an action may be brought to recover the payment.

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

WITNESS

NAME: _____

SSN: _____

EMPLOYER'S CERTIFICATION OF TERMINATION

INSTRUCTIONS: The Employer must complete this Certification of Termination and send it back to the Board of Trustees with a copy to the Local Board.

NAME OF EMPLOYER: _____

Applicant's final wage period was from _____ through _____

Last date of employment: _____

Employee contributions for final wage period by applicant total \$ _____

(The Board of Trustees will deduct prior payments, if any, made by the CORP to or on behalf of the applicant to arrive at refundable accumulated contributions. A.R.S. Sections 38-884 and 38-899)

The undersigned representative of the employer hereby certifies that the applicant named above has actually terminated his employment and agrees that any excess refund paid to the applicant due to an overstatement of the total aggregate employee contributions shall be the liability of the employer. I also acknowledge that the membership date and termination date provided by the employee above corresponds with the information in our personnel files.

EMPLOYER'S REPRESENTATIVE:

SIGNATURE	TITLE	TELEPHONE NUMBER	DATE
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If you have five or more years of credited service with the plan you are entitled to receive additional monies according to the following schedule:

- 5 to 5.9—25% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-891, subsection B.
- 6 to 6.9—40% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-891, subsection B.
- 7 to 7.9—55% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-891, subsection B.
- 8 to 8.9—70% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-891, subsection B.
- 9 to 9.9—85% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-891, subsection B.
- 10 or more—100% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-891, subsection B, plus interest at 3% after 30 days if left on deposit.

All of the additional monies prescribed above are taxable monies. NOTE: Periods of time during which you were on a leave of absence without pay **do not** count as credited service.

LEAVES OF ABSENCE WITHOUT PAY (Complete only if you have five or more years of credited service)

During my periods of covered service, I have been on leave of absence without pay as indicated below: **(Initial and complete)**

- _____ (a) NONE
- _____ (b) From ____ / ____ / ____ Through ____ / ____ / ____ Employer _____
- From ____ / ____ / ____ Through ____ / ____ / ____ Employer _____
- From ____ / ____ / ____ Through ____ / ____ / ____ Employer _____

EMPLOYER'S CERTIFICATION OF INFORMATION
(Complete only if the employee has five or more years of credited service)

The undersigned representative of the employer hereby certifies that the periods of leave of absence without pay provided by the applicant named on the reverse hereof corresponds with the information in our personnel files.

EMPLOYER'S REPRESENTATIVE:

SIGNATURE	TITLE	TELEPHONE NUMBER	DATE
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