

FOR PSPRS USE ONLY

SYS: _____

ID: _____

DROP

DATE: ____/____/____

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016

(602)255-5575 FAX (602)296-2369 www.psprs.com

FORM P4 RDROP

09/09

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**APPLICATION FOR REVERSE
DEFERRED RETIREMENT OPTION PLAN**

DATE: ____/____/____

TO: LOCAL RETIREMENT BOARD

Having completed 20 or more years of credited service with the (employer name) _____, and having not previously elected to participate in the Deferred Retirement Option Plan (DROP) pursuant to A.R.S. section 38-844.03, I, (name) _____, hereby submit my application for the REVERSE DROP under the terms of the Arizona Public Safety Personnel Retirement System. I am electing to participate in the REVERSE DROP and terminate employment on (date) ____/____/____, acknowledging that my effective date of retirement will be the first day of the month following my date of the election (A.R.S. Section 38-844.10(D)(2)). I am further designating as my REVERSE DROP date ____/____/____ (This date cannot exceed 60 months prior to my termination of employment or my completion of 20 years of credited service) (A.R.S. Section 38-844.10(D)(1)). I understand that I will receive benefits from the system using the factors of credited service and average monthly benefit compensation in effect on the REVERSE DROP date (A.R.S. SECTION 38-844.10(D)(3)).

ADDRESS _____ HOME PHONE NUMBER (____) _____ - _____

WORK PHONE NUMBER (____) _____ - _____

EMAIL _____ CELL PHONE NUMBER (____) _____ - _____

SPOUSE

Name: _____ Date of Birth: ____/____/____ Date of Marriage: ____/____/____

Social Security Number: _____ - _____ - _____

DEPENDENT CHILDREN

NAME	DATE OF BIRTH	IS CHILD DISABLED?		Is child 18-22 and in school fulltime?	
		YES	NO	YES	NO
_____	____/____/____	YES	NO	YES	NO
_____	____/____/____	YES	NO	YES	NO
_____	____/____/____	YES	NO	YES	NO
_____	____/____/____	YES	NO	YES	NO
_____	____/____/____	YES	NO	YES	NO

NOTE: Please provide a copy of:

1. Your Birth Certificate
2. Your Marriage Certificate
3. Your Spouse's Birth Certificate
4. Your Dependent Children's Birth Certificates
5. Copy of Divorce Decree (no split with ex-spouse)
6. Certified Copy of Plan Approved Domestic Relations Order
7. Medical Documentation For Disabled Children. (If applicable)
8. Proof of Full-time School Enrollment (If applicable)

(NOTE: Please complete page)

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Name of Member: _____ S.S.N.: _____ - _____ - _____ Date: ____/____/____

1. LEAVE(S) WITHOUT PAY: During my period(s) of covered service, I have been on leave of absence without pay as indicated below:

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

2. INDUSTRIAL LEAVE: During my period(s) of covered service, I have received compensation benefits under the Worker's Compensation Laws of the State of Arizona as indicated below:

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

3. The information contained above is true, complete and correct to the best of my knowledge and belief. Further, I HEREBY AUTHORIZE the Local Board, the office of the Fund Manager and/or their authorized designee to procure from my employer(s) or from any other person, firm or corporation (including any governmental agency or department thereof) any and all information as directly related to leave(s) of absence without pay and/or application(s) for and/or receipt of Worker's Compensation Benefits. I expressly waive all provision of law forbidding any doctor, person, firm or corporation (including any governmental agency or department thereof) from disclosing any knowledge or information which they have in their possession concerning leave(s) of absence without pay and/or Worker's Compensation. This is a limited release and is only to be in effect from this date to 120 days after first receipt of my retirement benefits.

By completing and signing this application, I hereby acknowledge receiving and reading the attached memorandum of understanding and agreement relating to the REVERSE DROP requirements.

WITNESS SIGNATURE MEMBER'S SIGNATURE
DATE: ____/____/____

EMPLOYER'S CERTIFICATION OF PARTICIPATION IN THE REVERSE DROP

The date that the member elected to participate in the REVERSE DROP and terminate employment is ____/____/____.

BY: _____ Signature and Title