

MEMBERSHIP FORM

PLEASE PRINT

INTERSYSTEM TRANSFER

U2 TRANSFER

_____ 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 Birth Date Number of Children under 18

1. Were you previously employed as a police officer **or** fire fighter in the State of Arizona?

If yes, please fill in the following:

	<u>FROM</u>	<u>THROUGH</u>	<u>TITLE OF POSITION</u>	<u>EMPLOYER</u>
A.	_____	_____	_____	_____
B.	_____	_____	_____	_____

2. Was a refund issued? Circle **Y** or **N**

3. A refund will NOT be issued while you are employed with the same/or another Public Safety employer.

I declare under penalty of perjury that the above information is true, correct and complete, to the best of my knowledge and belief. (A person who knowingly makes any false statement or who falsifies or permits to be falsified any record of the System with an intent to defraud such System is guilty of a Class 6 felony. A.R.S. Section 38-849.B)

_____ Date _____ Signature of Employee

EMPLOYER ACKNOWLEDGMENT

_____/_____/_____
Membership Date (with current employer) Employer

_____ \$ _____
Position and Classification (Employee Must Work Full Time 40+ Hours Per Week To Be Eligible) 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 by the member 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 System 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 _____, 20 _____.
(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: Public Safety Personnel Retirement System
3010 E. Camelback Rd., Suite 200
Phoenix, Arizona 85016