

**APPLICATION FOR DEFERRED RETIREMENT OPTION PLAN**

TO: LOCAL RETIREMENT BOARD

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Having completed 20 or more years of credited service with the (employer name) \_\_\_\_\_, I, (name) \_\_\_\_\_, hereby submit my application for the deferred retirement option plan (DROP) under the terms of the Arizona Public Safety Personnel Retirement System. I am electing to participate in the DROP on (date) \_\_\_\_/\_\_\_\_/\_\_\_\_, acknowledging that my effective date of participation in the DROP will be the first day of the month following my date of the election and that payments will be credited to my DROP account on or about the last day of the month following my DROP effective date (A.R.S. Section 38-844.03). I voluntarily and irrevocably designate a period of \_\_\_\_\_ months (can not exceed 60 months) as the period I wish to participate in the DROP. I understand that by participating in DROP, I must terminate employment with my employer on or before \_\_\_\_/\_\_\_\_/\_\_\_\_. I understand there are certain consequences if I do not terminate by this date.

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. If Divorced during period of employment:
  - a. Photocopy of complete Divorce Decree, or
  - b. Certified Copy of Plan-Approved Domestic Relations Order
6. Medical Documentation For Disabled Children. (If applicable)
7. Proof of Full-time School Enrollment (If applicable)

**(NOTE: Please complete 2<sup>nd</sup> page)**

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FORM P4 DROP

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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 board of trustees 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 DROP requirements.

WITNESS SIGNATURE \_\_\_\_\_ MEMBER'S SIGNATURE \_\_\_\_\_
DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER'S CERTIFICATION OF DROP DATE

The date that the member elected to participate in the DROP program is \_\_\_\_/\_\_\_\_/\_\_\_\_.

After this date, employee and employer contributions will cease to be made to the PSPRS for members who had 20 years of credited service prior to 1/1/2012 (A.R.S. 38-844.06 (B)). Employees who had less than 20 years of credited service on 1/1/2012 and elect to participate in DROP after 1/1/2012 shall make employee contributions to PSPRS in the same manner as an active employee who has not elected to participate in DROP pursuant to A.R.S. 38-843.

BY: \_\_\_\_\_
Signature
Title