

**APPLICATION FOR NORMAL RETIREMENT**

TO: LOCAL RETIREMENT BOARD

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

Having either (1) reached age 62 with 15 or more years of service **OR** (2) completed 20 or more years of service at time of termination with the (employer name) \_\_\_\_\_, I, (name) \_\_\_\_\_, hereby submit my application for normal retirement under the terms of the Arizona Public Safety Personnel Retirement System. I am retiring on (date) \_\_\_\_/\_\_\_\_/\_\_\_\_, acknowledging that the effective date of my retirement will be the first day of the month following the date of retirement, with payments beginning on or about the last day of that month (A.R.S. Section 38-844.(A)). If application is being made under A.R.S. Section 38-854, please state prior system law \_\_\_\_\_.

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)

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

**APPLICATION FOR NORMAL RETIREMENT**

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:

<input type="checkbox"/> (a) None	Missed Pay Periods	Employer
<input type="checkbox"/> (b)	1.	
	2.	
	3.	
	4.	
	5.	

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.

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

\_\_\_\_\_  
MEMBER'S SIGNATURE

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

**EMPLOYER'S CERTIFICATION OF RETIREMENT DATE:**

Member's employment will terminate on \_\_\_\_\_

BY \_\_\_\_\_  
Signature

\_\_\_\_\_  
Title