

**APPLICATION FOR DEFERRED ANNUITY**

TO: LOCAL RETIREMENT BOARD

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

Having completed 10 or more years of credited service with the (employer name) \_\_\_\_\_, and having attained age 62, I, (name) \_\_\_\_\_, hereby submit my application for a deferred annuity under the terms of the Arizona Public Safety Personnel Retirement System (A.R.S. Section 38-846.01). I am terminating on or have terminated on (date) \_\_\_\_/\_\_\_\_/\_\_\_\_, acknowledging that the effective date of my deferred annuity will be the first day of the month following the date of application, with payments beginning on or about the last day of that month. I also understand that if I die and I have accumulated contributions remaining in the system, those remaining accumulated contributions will be paid to my designated beneficiary, if living, or to my nearest living kin as selected by my local PSPRS board.

ADDRESS: \_\_\_\_\_

HOME PHONE NUMBER: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

\_\_\_\_\_

WORK PHONE NUMBER:(\_\_\_\_) \_\_\_\_ - \_\_\_\_

EMAIL: \_\_\_\_\_

CELL PHONE NUMBER:(\_\_\_\_) \_\_\_\_ - \_\_\_\_

**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 Certificate
5. If Divorced during period of employment:
  - a. Photocopy of complete Divorce Decree, or
  - b. Certified copy of Plan-approved Domestic Relations Order

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

**APPLICATION FOR DEFERRED ANNUITY**

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 annuity benefits.

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

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

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

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

Member's employment terminated on \_\_\_\_\_

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

\_\_\_\_\_  
Title