PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016
(602) 255-5575 FAX (602) 296-2368 www.psprs.com
EMAIL: ActiveMembersGroup@psprs.com

MEMBERSHIP FORM

PLEASE PRINT INTERSYSTEM TRANSFER U2 TRANSFER

Name | M F 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

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

***** SIGNATURE REQUIRED*** CANCER INSURANCE PROGRAM***:* Pursuant to A.R.S. § 38-644, I understand that I will be automatically enrolled in the Cancer Insurance Program as of my membership date acknowledged by my employer below. Information regarding this benefit can be found at www.psprs.com.

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