ELECTED OFFICIALS' RETIREMENT SYSTEM
3010 East Camelback Road, Suite 200
Phoenix, Arizona 85016-4416
(602) 255-5575 | www.psprs.com

FAX: (602) 296-2368
Email: *ActiveMembersGroup@psprs.com*

FORM E6
02/2024

APPLICATION FOR A SEPARATION BENEFIT/DEFERRED BENEFIT

PRINT INFORMATION:					
NAME:		**EMAIL:**		**SSN:**	
MAILING ADDRESS					
(STREET)		**(APT#)**		**(CITY, STATE & ZIP CODE)**	
PHONE NUMBER		**BIRTH DATE:** *(MM/DD/YYYY)*			

MY ELECTION TO THE OFFICE OF: _____

BEGAN ON *(MM/DD/YYYY)* _____ **AND TERMINATED ON** *(MM/DD/YYYY)* _____

I certify *that I have terminated my employment and have not previously received a refund of my contributions to the Plan. The dates of membership and termination in this application and the periods of leave of absence without pay are correct; I understand the terms and requirements for the Refund Option and the Deferred Pension Option below; and I make* ***my election*** *as indicated below:*

REFUND OPTION

By INITIALING _____ this Refund Option, I HEREBY make application for the refund of my contributions to the ELECTED OFFICIALS' RETIREMENT PLAN as well as any enhanced refund as provided by law. I fully understand that if I have five (5) or more years of membership under the Plan, that I may elect early retirement or elect a deferred option (see below). I understand that by withdrawal of my contributions, I am forfeiting these rights and any other rights to benefits under the Plan, that my service credits therein will be cancelled, and membership will cease (A.R.S. § 38-804). Further, I understand that if I am again employed in a position covered under the Plan, these service credits may be reinstated only if a written election is filed with the Board of Trustees within ninety (90) days of taking office and I redeposit my refund contributions within one (1) year, along with interest to date of redeposit (A.R.S. § 38-804). I further understand that pursuant to A.R.S. § 38-921, I may be entitled to transfer my service credits to a new state retirement system upon subsequent employment in a position not covered by EORP and that by withdrawing my contributions, I am forfeiting all of these rights. **If you elect the REFUND OPTION, a refund check will be mailed to the address shown above or the designated financial institution(s) on the attached forms(s), or per my request will be direct deposited after this application is filed and my final wage deduction is transmitted to this office and my termination of covered employment has been verified by the appropriate governing authority.**

DEFERRED PENSION OPTION

By INITIALING _____ this Deferred Pension Option and having five (5) or more years of credited service, I ELECT to leave my contributions on deposit in anticipation of requesting a normal retirement benefit at such time that I become eligible, in accordance with the age requirements as defined in A.R.S. Section 38-805. I understand that election of this option is not binding and that, at my discretion, I may wish to elect a refund or early retirement at some point in time in the future. My final annual salary was $_____. **If you elect the DEFERRED OPTION and subsequently change your address or name, you must notify this office.**

TAXABLE MONIES

******You must complete the information below before a refund check is issued.***

By INITIALING_____, I understand and acknowledge the following:

1. I am aware that I have at least 30 days to decide whether I want to elect a direct rollover or to elect a cash distribution of my taxable monies and I am electing to waive this 30-day waiting period.
2. I have completed the Lump Sum Distribution Election Form that prescribes certain tax consequences regarding the above taxable monies.
3. I have received and read the special tax notice regarding these taxable monies and understand the tax consequences explained in the notice and election form.

If this application form is <u>not signed and notarized</u> or if the LUMP SUM DISTRIBUTION ELECTION FORM is not completed, <u>it will be returned</u> which will cause a delay in the processing of any enhanced portion of your refund.

Go to page 2 for the employee signature and ***Notary Acknowledgement section*** of the form.
**Page 1 and 2 of this form should be initialed & signed in the presence of a notary public.*

If you divorced during your employment, provide our office with a copy of your Divorce Decree or Domestic Relations Order. NOTE: A.R.S. §§ 38-860, 38-910, 38-822 states that if you have been involved in a divorce, the System/Plan is **not** liable for any benefits you receive. You are considered trustee to the funds and will be the sole party against with whom an action may be brought to recover the payment.

I declare under penalty of perjury that the above information is true, correct, and complete to the best of my knowledge and belief.

DATE **EMPLOYEE'S SIGNATURE**

**Please date and sign in the presence of a notary public.*

NOTARY ACKNOWLEDGMENT

STATE OF ARIZONA

COUNTY OF _____)

On this _____ day of _____, 20_____, before me personally
[Day] [Month] [Year]

appeared _____, whose identity was proven
[Name of signer]

to me on the basis of satisfactory evidence to be the person who he or she claims to be and acknowledged that he or she signed the above / attached: Application for a Separation Benefit/Deferred Benefit Form.

(Seal) [Affix Seal Here] **Notary Public [Notary Public Signature]**

Go to page 3 for Employer Certification information.
(Submit Page 3, Employer Certification of Termination to your employer's payroll office).

NAME: _____ **Form E6**

SSN: _____ ***ActiveMembersGroup@psprs.com***

EMPLOYER'S CERTIFICATION OF TERMINATION

INSTRUCTIONS: **The Employer must complete this Certification of Termination and send it back to the Board of Trustees.**

NAME OF GOVERNING AUTHORITY: _____

Applicant's final pay period was from ***(MM/DDYYYY)***: _____ through ***(MM/DDYYYY)*** _____

Last date of employment: ***(MM/DDYYYY)*** _____

Employee contributions for final wage period by applicant total $ _____

The undersigned representative of the employer hereby certifies that the applicant named above has actually terminated his employment and agrees that any excess refund paid to the applicant due to an overstatement of the total aggregate employee contributions shall be the liability of this governing authority. I also acknowledge that the membership date and termination date provided by the employee above corresponds with the information in our personnel files.

GOVERNING AUTHORITY'S REPRESENTATIVE:

SIGNATURE	**TITLE**	**TELEPHONE NUMBER**	**DATE**

If a member who became a member of the plan before January 1st, 2012, and has five or more years of credited service with the plan you are entitled to receive additional monies according to the following schedule:

5 to 5.9—25% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-810, subsection A.
6 to 6.9—40% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-810, subsection A.
7 to 7.9—55% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-810, subsection A.
8 to 8.9—70% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-810, subsection A.
9 to 9.9—85% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-810, subsection A.
10 or more—100% of member contributions deducted from the member's salary pursuant to A.R.S. § 38-810, subsection A, plus interest at 3% after 30 days if left on deposit.

Otherwise, if you were a member of the system on or after January 1st, 2012 you shall be paid the member's accumulated contributions plus interest at a rate determined by the board. (Currently 3%)

All of the additional monies prescribed above are taxable monies. **NOTE**: Periods of time during which you were on a leave of absence without pay **do not** count as credited service.

LEAVES OF ABSENCE WITHOUT PAY (Complete only if you have five or more years of credited service)

During my periods of covered service, I have been on leave of absence without pay as indicated below: **(Initial and complete)**

(a) _____ **NONE**

(b) _____ **FROM** ***(MM/DDYYYY)*** _____ **THROUGH** ***(MM/DDYYYY)*** _____ **EMPLOYER** _____

FROM ***(MM/DDYYYY)*** _____ **THROUGH** ***(MM/DDYYYY)*** _____ **EMPLOYER** _____

FROM ***(MM/DDYYYY)*** _____ **THROUGH** ***(MM/DDYYYY)*** _____ **EMPLOYER** _____

EMPLOYER'S CERTIFICATION OF INFORMATION
(Complete only if the employee has five or more years of credited service)

The undersigned representative of the employer hereby certifies that the periods of leave of absence without pay provided by the applicant named on the reverse hereof corresponds with the information in our personnel files.

EMPLOYER'S REPRESENTATIVE:

SIGNATURE	**TITLE**	**TELEPHONE NUMBER**	**DATE**