ELECTED OFFICIALS' RETIREMENT PLAN

3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016
(602)255-5575 FAX (602)296-2368 www.psprs.com

MEMBERSHIP FORM

NAME: _____ SEX: M F MARITAL STATUS: _____

SOCIAL SECURITY NUMBER: _____ BIRTH DATE: _____

ADDRESS: _____
(Street) (Apt No.) (City) (State) (Zip)

HOME TELEPHONE NUMBER: _____ E-MAIL: _____

I AM EMPLOYED BY: (CHECK ONLY ONE)

☐ STATE OF ARIZONA

☐ COUNTY OF: (CIRCLE ONE) APACHE COCHISE COCONINO GILA GRAHAM
GREENLEE LA PAZ MARICOPA MOHAVE NAVAJO
PIMA PINAL SANTA CRUZ YAVAPAI YUMA

☐ TOWN OF: _____

☐ CITY OF: _____

POSITION TITLE: _____

MEMBERSHIP DATE: _____ **CURRENT ANNUAL SALARY:** _____

NAME OF SPOUSE: _____ SPOUSE'S BIRTH DATE: _____

SPOUSE'S SOCIAL SECURITY NUMBER: _____ NUMBER OF CHILDREN UNDER AGE 18: _____

BIRTH DATE(S): _____ _____ _____ _____ _____

PREVIOUS EMPLOYMENT: APPLIES ONLY TO PERIODS OF SERVICE AS AN ELECTED OFFICIAL WHICH OCCURRED PRIOR TO MEMBERSHIP DATE SHOWN ON THIS FORM.

	FROM	THROUGH	TITLE OF POSITION	EMPLOYER
1.				
2.				

At completion of the term(s) of office as indicated above, was a refund of Member Contributions processed? Yes No

If I am a State Elected Official who is subject to term limits, by signing this membership form I understand that I had the option to elect not to participate in the Plan but by signing this Membership Form I agree to participate in the Elected Officials' Retirement Plan.

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

DATE: _____ EMPLOYEE'S SIGNATURE _____

E M P L O Y E R A C K N O W L E D G E M E N T

I hereby acknowledge that the Membership Date and Position Title 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 COMPLETE BENEFICIARY INFORMATION ON NEXT PAGE

B E N E F I C I A R Y D E S I G N A T I O N

NAME: _____ SSN: _____

In the event of my death, **and after any survivor pension payable from the Plan 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 Board of Trustees. 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, THIS _____ DAY OF _____ , 20 _____ .
CITY OR TOWN **DAY** **MONTH** **YEAR**

_____
SIGNATURE OF EMPLOYEE

_____ _____
NAME OF WITNESS-PRINTED SIGNATURE OF WITNESS

(Witness must be person other than beneficiaries named above)

When completed, mail to: Elected Officials' Retirement Plan
3010 E. Camelback Rd., Suite 200
Phoenix, Arizona 85016