



Article 15 Membership Registration

RS 5420-I

Internet Version (Rev. 11/00)

New York State and Local Retirement Systems, Gov. Smith State Office Building, Albany, New York 12244-0145

IF YOUR MEMBERSHIP IS OPTIONAL, DO NOT COMPLETE OR SUBMIT THIS FORM UNLESS YOU DESIRE TO BECOME A MEMBER.

If your employment is on a part-time, temporary or provisional basis, or less than 12 months per year, membership is optional.

Instructions: Please print plainly or type.

This form must be signed and notarized on reverse side.

Employee: Complete items 1-7 and reverse side.

Employer: Complete the Important Information box and Items 8-13.

FOR REGISTRATION NUMBER CALL: (518) 474-3081 or fax the application at (518) 486-4382.

This completed membership application must be mailed to the Retirement System for the membership to be effective.

IMPORTANT INFORMATION: Has this person been registered to membership by means of the telephone or fax registration system? Yes No (If yes, enter the information given to you in the boxes below.)

In order to complete the registration process this membership registration form must be received by the Retirement System.

Location Code				Plan Code	Group Code	Date of Membership			Arrears Code	Registration Number			
						Mo.	Day	Yr.					

Receipt Stamp For ERS purposes only

Employee's Name Last					First					Middle Initial		
1												

Employee's Address Street							City			State	Zip Code + 4			
2														

3 Date of Birth			Sex	*Social Security Number					Maiden or Other Name Used				
Month	Day	Year	M <input type="checkbox"/> F <input type="checkbox"/>										

*Social Security Number Required (See Note at Bottom of Page)

Are you currently a member of any other public retirement system? <input type="checkbox"/> YES <input type="checkbox"/> NO										
If yes, what is the name of the system?						What REGISTRATION NUMBER (If Known)?				
4										

WARNING: If you are now a member of any other public retirement system in New York State, you should contact that system concerning the advantages of transferring your membership to this system. Failure to contact that system could cause loss of the privilege of transferring membership.

Have you ever been a member of the New York State Employees' Retirement System? <input type="checkbox"/> YES <input type="checkbox"/> NO										
If yes, under what name?						What REGISTRATION NUMBER (If Known)?				
5										

Are you receiving or are you about to begin receiving a RETIREMENT BENEFIT from any retirement system on THE BASIS OF EMPLOYMENT with New York State or any public entity in the State? <input type="checkbox"/> YES <input type="checkbox"/> NO										
If yes, what is the name of the System?						What REGISTRATION NUMBER or RETIREMENT NUMBER (If Known)?				
6										

List below all previous periods of employment with New York State or any New York State public entity (County, City, Town, Village, School District, Public Authority, or Special District). Include any military service. Attach additional sheets if required.

7	Name of Employer	Name of Dept. or Agency	Title of Position	From			To			Indicate If Permanent or Temporary, and Full or Part Time
				Mo.	Day	Year	Mo.	Day	Year	

To be completed by present employer:

8 Employer Name (Indicate State, or, if not, name of public entity by which employed and Department, Division, or Institution)										
--	--	--	--	--	--	--	--	--	--	--

9 Employer's Address Street				City	County	State	Zip Code +4				Employer Telephone Number
											()

10 Payroll Title							Employer Fax Number				
							Indicate Length of Work Year <input type="checkbox"/> 10 Months <input type="checkbox"/> 12 Months <input type="checkbox"/> Seasonal				
											()

Enter the Date or Dates Relating to Employee's Present Position

11 Part-Time Employment						Full-Time Employment					
Date of First Appointment			Date of Permanent Appointment			Date of Temporary or Provisional Appointment			Date of Permanent or Probationary Appointment		
Month	Day	Year	Month	Day	Year	Month	Day	Year	Month	Day	Year

12 Frequency of Payment										
Annually <input type="checkbox"/>	Semi-Annually <input type="checkbox"/>	Quarterly <input type="checkbox"/>	Monthly <input type="checkbox"/>	If Other Specify _____						
Semi-Monthly <input type="checkbox"/>	Bi-weekly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Other <input type="checkbox"/>							

13 Basis of Compensation and Rate											
Annual \$ _____			Daily \$ _____			Hourly \$ _____			Maintenance Allowance (if any)		
Units of Work Performed \$ _____ per _____			(Example: \$50 per meeting or \$10 per examination, etc.)								

*NOTE: In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of your Social Security account number is mandatory pursuant to Sections 11 and 34 of the Retirement and Social Security Law. Your number will be used in identifying your retirement records and in the administration of the Retirement System.

NOTE: In accordance with the Personal Privacy Protection Law you are hereby advised that pursuant to the Retirement and Social Security Law, the Retirement System is required to maintain records. The records are necessary to determine eligibility for and to calculate benefits. Failure to provide information may result in the failure to pay benefits. The System may provide certain information to participating employers. The official responsible for maintaining these records is the Director of Member Services, New York State and Local Retirement System, Albany, NY 12244-0145; telephone number (518) 474-3524.

To Be Completed by Employee (Also see reverse side)

To Be Completed by Employer

Important: If you find this form is not suited for the type of Designation you prefer, please advise the Retirement System. In the meantime, for your protection and the protection of your beneficiary(ies), you should

make an interim designation using this form. Beneficiaries' complete name, address, date of birth and relationship must be provided. Do *not* designate yourself. If additional space is needed you may enter two names on a line. **This is a legal document and, therefore, this form must not be altered.**

**14 To the Comptroller of the State of New York.
Designation of Primary Beneficiary(ies)**

I hereby name the following as beneficiary(ies) to receive any death benefit payable on my behalf. I realize that, if a death benefit is payable for which the beneficiaries are mandated by law, this designation will be superseded. If I have named more than one

beneficiary, it is my intention that those living at the time of my death should share equally any benefit payable. I reserve the right to change the designation at any time.

Name <input type="checkbox"/> Male <input type="checkbox"/> Female	Name <input type="checkbox"/> Male <input type="checkbox"/> Female
Birth Date Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other	Birth Date Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other
Address	Address
Name <input type="checkbox"/> Male <input type="checkbox"/> Female	Name <input type="checkbox"/> Male <input type="checkbox"/> Female
Birth Date Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other	Birth Date Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other
Address	Address

15 Designation of Contingent Beneficiary(ies)

If all the above named beneficiaries die before I do, any benefits payable on my behalf shall be paid to the following. I realize that, if a death benefit is payable for which the beneficiaries are mandated by law, this designation will be superseded. If I have named more than

one beneficiary, it is my intention that those living at the time of my death should share equally any benefit payable. Furthermore, if I should out-live all these beneficiaries, any benefit payable should be paid to my estate or any other beneficiary I name hereafter. I reserve the right to change the designation at any time.

Name <input type="checkbox"/> Male <input type="checkbox"/> Female	Name <input type="checkbox"/> Male <input type="checkbox"/> Female
Birth Date Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other	Birth Date Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other
Address	Address
Name <input type="checkbox"/> Male <input type="checkbox"/> Female	Name <input type="checkbox"/> Male <input type="checkbox"/> Female
Birth Date Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other	Birth Date Relationship (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other
Address	Address

16 If you were previously a member of any public retirement system in New York State you may be eligible for tier reinstatement. To apply for tier reinstatement, please complete this section.

FORMER MEMBERSHIP INFORMATION:

PLEASE CHECK THE APPROPRIATE FIRST FORMER RETIREMENT SYSTEM YOU WERE A MEMBER OF:

- | | |
|---|---|
| <input type="checkbox"/> New York State Teachers' Retirement System | <input type="checkbox"/> New York City Board of Education Retirement System |
| <input type="checkbox"/> New York State and Local Employees' Retirement System | <input type="checkbox"/> New York City Teachers' Retirement System |
| <input type="checkbox"/> New York State and Local Police and Fire Retirement System | <input type="checkbox"/> New York City Police Pension Fund |
| <input type="checkbox"/> New York City Employees' Retirement System | <input type="checkbox"/> New York City Fire Pension Fund |

PLEASE COMPLETE THE FOLLOWING (if known):

Former Registration Number: _____ Date of Membership: _____

Former Name (if applicable): _____

Have you received credit for this former membership in any other retirement system? Yes _____ No _____

If Yes, what Retirement System _____

Are you receiving or eligible to receive a retirement allowance based on this service? Yes _____ No _____

Signature _____ Date _____

17 I have made my Designation of Beneficiary as shown above and acknowledge that my membership in the New York State and Local Employees' Retirement System is governed by the provisions of Article 15 of the Retirement and Social Security Law and that I am entitled to all the benefits thereof. I understand that, as required by law, a 3% deduction will be made from my salary or compensation for retirement contributions until such time that I have been a member of the Retirement System for ten years or have ten years of credited service.

Signature _____

Date _____

**ACKNOWLEDGEMENT
TO BE COMPLETED BY A NOTARY PUBLIC**

State of _____

County of _____ ss:

On this _____ day of _____, 20____ before me personally appeared _____ to me known and known to me to be the same person described in and who executed the foregoing instrument, and ___ he duly acknowledged to me that ___ he executed the same.

Notary Public
(Please Sign, Affix Stamp and Include Expiration Date)

Reviewed

FOR OFFICE USE ONLY

Examined