

CORRECTIONS OFFICER RETIREMENT PLAN

INPUT FORM B

EIN: _____

(Please fill in all of the information on this form. If not applicable, please indicate.)

INPUT SHEET FOR (select one):

___ SURVIVING SPOUSE

Today's Date: _____

___ GUARDIAN OF DECEDENT'S DEPENDENT CHILDREN

Date of Death: _____

___ DESIGNATED BENEFICIARY

Was member Retired at Date of Death? Y N

___ PERSONAL REPRESENTATIVE OF DECEDENT'S ESTATE

PERSONAL INFORMATION OF DECEDENT

Name: _____
 First Middle Last Social Security Number

Sex (circle) M F Date of Birth: _____ Marital Status (circle) M S

APPLICANT INFORMATION

Name: _____
 First Middle Last Social Security Number

Date of Birth: _____ Date of Marriage (if Surviving Spouse): _____

ADDRESS AND TELEPHONE NUMBER OF APPLICANT MEMBER

Address: _____
 Street Apt. City State Zip Code

Phone: Home () _____ Cell () _____ Work () _____

Personal Email _____

IF BENEFICIARY OR REPRESENTATIVE, SIGN AT BOTTOM. IF SURVIVING SPOUSE OR GUARDIAN, CONTINUE

DEPENDENT CHILDREN OF DECEDENT++

Name	Date of Birth	Disabled?
_____	_____	Y** N
_____	_____	Y N
_____	_____	Y N

DECEDENT EMPLOYMENT INFORMATION

Current Employer: ADC
 Service From _____ To _____
 Local Board Name: CORP

APPLICANT PAYMENT INFORMATION	Payment Method (circle): Check Direct Deposit
Payable to: _____	Federal Tax (circle): Single/Married Exemptions: _____
	State Tax (circle): 0.8% 1.3% 1.8% 2.7% 3.6% 4.2% 5.1%

APPLICANT DIRECT DEPOSIT INFORMATION

Name of Financial Institution: _____ Phone Number: _____

Address: _____ ABA Routing No.: _____
 Street City State Zip Code

Account Type (circle one): Checking Savings Account No.: _____

BENEFICIARY (of the APPLICANT)

Primary Beneficiary: _____

Date of Birth: _____ Social Security Number: _____

Relationship(s): _____ Phone Number _____

Address: _____

Secondary Beneficiary: _____

Date of Birth: _____ Social Security Number: _____

Relationship(s): _____ Phone Number _____

Address: _____

Secondary Beneficiary: _____

Date of Birth: _____ Social Security Number: _____

Relationship(s): _____ Phone Number _____

Address: _____

I CERTIFY THE ACCURACY OF THE INFORMATION GIVEN ON THIS FORM

Date Signature of Applicant

Date Institution Employer's Authorized Signature Title

Note: Please provide a copy of: Death Certificate
State Issued Birth Certificate or Passport (for Applicant and Dependent Children)
Recorded Marriage Certificate (if Spouse)
State Issued Driver License or ID (for Applicant)
Social Security Card (for Applicant)
++Proof of Full Time school enrollment (up to age 23)
Proof of Disability prior to age 23 (for Dependent Children)

Also need Voided Check (Survivor OR Guardian Benefit Only)