



Office of the New York State Comptroller
 New York State and Local Retirement System
 Employees' Retirement System
 Police and Fire Retirement System
 110 State Street, Albany, New York 12244-0001

Article 15 Membership Registration

RS 5420

(Rev. 11/08)

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 complete in ink or type.

This form must be signed and notarized on reverse side.

Receipt Stamp
For OSC use only

Employee: Complete items 1-7 and reverse side.

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.)

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

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

1 Employee's Name		Last	First	Middle Initial
2 Employee's Address		Street and/or PO Box #	City	State Zip Code + 4
3 Date of Birth		Month	Day	Year
		Sex	Social Security Number	
		M F	*Social Security Number	
		<input type="checkbox"/> <input type="checkbox"/>	Maiden or Other Name Used	
Social Security Number Required (See Note at Bottom of Page)				

4 Are you currently a member of any other public retirement system?
 If yes, what is the name of the system? YES NO
 What REGISTRATION NUMBER (if known)?

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.

5 Have you ever been a member of the New York State Employees' Retirement System?
 If yes, under what name? YES NO
 What REGISTRATION NUMBER (if known)?

6 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?
 If yes, what is the name of the System? YES NO
 What REGISTRATION NUMBER or RETIREMENT NUMBER (if known)?

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			

8 To be completed by present employer:
 Employer Name (Indicate State, or, if not, name of public entity by which employed and Department, Division, or Institution)
 Tompkins County Personnel Dept.

9 Employer's Address
 Street City County State Zip Code + 4
 125 E. Court St. Ithaca Tompkins N Y 1 4 8 5 0 (607) 274-5525

10 Payroll Title
 Check if Either Applies
 Appointed Official Elected Official
 *If accountant, auditor, physician, attorney, engineer or architect please submit documentation as indicated at www.osc.state.ny.us/retire/employers/employee-contractor_guidelines/certification_form.pdf
 Indicate Length of Work Year 10 Months 12 Months Seasonal
 Employer Fax Number (607) 274-5401

11 Enter the Date or Dates Relating to Employee's Present Position
 Part-Time Employment
 Date of First Appointment Date of Permanent Appointment
 Month Day Year Month Day Year
 Full-Time Employment
 Date of Temporary or Provisional Appointment Date of Permanent or Probationary Appointment
 Month Day Year Month Day Year

12 Frequency of Payment
 Annually Semi-Annually Quarterly Monthly
 Semi-Monthly Bi-weekly Weekly Other
 If Other Specify _____

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

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 Section 16. (For previous Tier 1 or 2 Memberships only.)

FORMER MEMBERSHIP INFORMATION:

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

- New York State Teachers' Retirement System
- New York State and Local Employees' Retirement System
- New York State and Local Police and Fire Retirement System
- New York City Employees' Retirement System
- New York City Board of Education Retirement System
- New York City Teachers' Retirement System
- New York City Police Pension Fund
- 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 benefit based on this service? Yes _____ No _____

Signature _____ Date _____

17 IMPORTANT: You must sign and enter date below to affirm Retirement System membership, and beneficiary designation.

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.

ACKNOWLEDGEMENT TO BE COMPLETED BY A NOTARY PUBLIC
 State of _____ County of _____
 On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____
 personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Signature _____

NOTARY PUBLIC (Please sign and affix stamp)

Date _____

Notary Stamp

FOR OFFICE USE ONLY

Reviewed	Examined
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