

# Employees' Retirement System Membership Registration RS 5420

(Rev. 8/16)

If your employment is on a part-time, temporary or provisional basis, or less than 12 months per year, membership is optional.  
**IF YOUR MEMBERSHIP IS OPTIONAL, DO NOT COMPLETE OR SUBMIT THIS FORM UNLESS YOU DESIRE TO BECOME A MEMBER.**

**Instructions:** Please print clearly in ink or type. **Application must be signed on last page. Notarization is no longer required.**  
**Employee:** Complete items 1-3, 10-13 on page 2 and other applicable sections. **Employer:** Complete items 4-9a.  
**FOR A REGISTRATION NUMBER:** Call 1-866-805-0990 or (518) 474-3081. Or fax the application to (518) 486-4382.  
**This completed membership application must be mailed to the Retirement System for the membership to be effective.**

<b>Receipt Stamp</b> For OSC use only

**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		Report Code	Plan Code	Group Code	Date of Membership			Tier	Registration Number					Rate		
					Mo.	Day	Year									

To Be Completed by Employee (Also see reverse side)

<b>1 Employee's Name</b> Last	First	Middle Initial
<b>1</b>		

<b>2 Employee's Address</b> Street and/or PO Box #	City	State	Zip Code + 4
<b>2</b>			

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

\*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.

To Be Completed by Present Employer

<b>4 Employer Name</b> (Indicate State, or, if not, name of public entity by which employed and Department, Division, or Institution)
<b>4</b>

<b>5 Employer's Address</b> Street	City	County	State	Zip Code + 4	<b>Employer Telephone Number</b>
<b>5</b>					( )

<b>6 Payroll Title:</b>		<b>Indicate Length of Work Year</b>	<b>Employer Fax Number</b>
		<input type="checkbox"/> 10 Months <input type="checkbox"/> 12 Months <input type="checkbox"/> Seasonal	( )
<b>Check if Either Applies</b>		*If accountant, auditor, physician, attorney, engineer or architect please submit documentation as indicated at <a href="http://www.osc.state.ny.us/retire/employers/classify_an_employee.php">www.osc.state.ny.us/retire/employers/classify_an_employee.php</a>	
<input type="checkbox"/> Appointed Official <input type="checkbox"/> Elected Official			

<b>7 Enter the Date or Dates Relating to Employee's Present Position:</b>											
<b>Part-Time Employment</b>						<b>Full-Time Employment</b>					
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

<b>8 Frequency of Payment:</b>
<input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Other - Please Specify _____

<b>9 Basis of Compensation and Rate (Tier 1, 2, 3, 4 and 5 ONLY):</b>
Annual \$ _____ Daily \$ _____ Hourly \$ _____ Units of Work Performed \$ _____ per _____ (Example: \$50 per meeting or \$10 per examination, etc.)

<b>9a Basis of Compensation and Rate (Tier 6 ONLY):</b>	Tier 6 requires employers to determine the Annual Wage for individuals who work Part Time, Seasonal or on an Hourly, Daily or Unit of Work Basis. See the Chart on Page Two for instructions.
<b>9a</b> Annual Wage \$ _____	

Name: \_\_\_\_\_

**Examples of Tier 6 annual wage for individuals paid at an Hourly, Daily or Unit of Work basis of compensation:**

<p><b>Hourly Employees</b></p> <p>12 month Employee: \$ _____ x _____ x 260 = \$ _____  <small>Hourly Rate                  Standard Workday*          Days Worked                  Annual Wage</small></p> <p>10 month Employee: \$ _____ x _____ x 180 = \$ _____  <small>Hourly Rate                  Standard Workday*          Days Worked                  Annual Wage</small></p>	<p><b>Daily Employees</b></p> <p>12 month Employee: \$ _____ x 260 = \$ _____  <small>   Daily Rate                  Days Worked                  Annual Wage</small></p> <p>10 month Employee: \$ _____ x 180 = \$ _____  <small>   Daily Rate                  Days Worked                  Annual Wage</small></p>
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\*Standard Workday (Hrs/day) (Applies to all Tiers): The minimum number of hours that can be established for a standard workday is six, while the maximum is eight. A standard workday is the denominator to be used for the days worked calculation; it is not necessarily the number of hours the person actually worked. For example, if a bus driver works four hours a day, you must still establish a standard workday between six and eight hours as the denominator for their days worked calculation.

<p><b>Unit of Work Employees</b></p> <p>\$ _____ x _____ = \$ _____  <small>Unit Rate                  # of Events**                  Annual Wage</small></p> <p>**Estimated or Actual</p>	<p><b>Example: Paid \$50 per Meeting</b></p> <p>\$ 50 x 12 Meetings = \$ 600  <small>Unit Rate                  # of Events***                  Annual Wage</small></p> <p>***An estimate of the number of events is acceptable</p>
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**Note:** Any questions regarding annual wage, please contact the Retirement System.

Are you currently an <b>active</b> or <b>vested</b> member of <b>any other</b> public retirement system in New York State? <span style="float: right;"><input type="checkbox"/> YES    <input type="checkbox"/> NO</span>	
If yes, what is the name of the system? <b>10</b>	REGISTRATION NUMBER (If Known?)

**WARNING:** If you are now an active or vested 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 and may effect contribution cessation dates.

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? <span style="float: right;"><input type="checkbox"/> YES    <input type="checkbox"/> NO</span>	
11	REGISTRATION NUMBER (If Known?)

Have you ever been a member of the New York State Employees' Retirement System? <span style="float: right;"><input type="checkbox"/> YES    <input type="checkbox"/> NO</span>	
12	REGISTRATION 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 as required.

13	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	

**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 maintaining these records is the Director of Member Services, New York State and Local Retirement System, Albany, NY 12244; telephone number 1-866-805-0990.

To Be Completed by the Employee

Name: \_\_\_\_\_

## Reinstatement to a former membership in accordance with Section 645 (Tiers 3, 4, 5 and 6).

**Note: Completion of this form does not constitute an application for reinstatement.**

Section 645 of the Retirement and Social Security Law allows members of a New York State public retirement system, whose original membership was terminated or withdrawn, to return to their former Tier or date of membership.

Members with a former Tier 3, 4, 5 or 6 membership in the New York State and Local Employees' Retirement System will be automatically provided with the cost, if any, and procedures for reinstatement at a later date.

Former Tier 3, 4, 5 or 6 members of any NYS public retirement system, *other than the NYS Employees' Retirement System*, **please complete the section below.** We will provide you with the cost, if any, and procedures for reinstatement at a later date.

## Reinstatement to a former membership in accordance with Section 645 (Tiers 1 and 2).

Members with a former Tier 1 or 2 membership in any New York public retirement system may apply for reinstatement by completing the section below.

### Important Information:

If you are not sure of your employer's current Tier 1 or 2 retirement plan, or if you are a member of the Police and Fire Retirement System or if you have any questions regarding reinstatement you should contact the Retirement System before completing the section below.

If you are given Tier 1 or 2 status, your Tier 3, 4, 5 or 6 contributions are **not refundable** and you will not be able to take a loan against these contributions.

If your date of membership will be before April 1, 1960, you may owe contributions for services rendered prior to April 1, 1960. Any deficit in contributions for service before the date noted will result in a reduction of your retirement benefit.

### FORMER MEMBERSHIP INFORMATION:

PLEASE CHECK THE 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 benefit based on this service? Yes  No

Signature \_\_\_\_\_ Date \_\_\_\_\_

If you are eligible for a refund of contributions, the Retirement System is required to withhold 10% of the taxable amount of the refund for federal taxes unless you instruct us not to take the withholding.

If you do not want the Retirement System to withhold federal income tax from your payment, sign and date this election.

**I DO NOT WANT TO HAVE FEDERAL INCOME TAX WITHHELD FROM MY PAYMENT.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

If you have not already done so, please complete an RS5127 Designation of Beneficiary With Contingent Beneficiaries form to designate beneficiary(ies) to receive an Ordinary Death Benefit. If there is no RS5127 Designation of Beneficiary With Contingent Beneficiaries form on file with this System, your Ordinary Death Benefit will become payable to your estate.

**WARNING:** If you are receiving a pension from a public retirement system in New York State, contact the system providing your pension BEFORE signing this form. Failure to do so could result in the suspension of payment of your pension benefit.

**IMPORTANT:** You must sign and enter date below to affirm Retirement System membership.

I 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 deduction will be made from my salary or compensation for retirement contributions.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Employee Telephone Number\*

Employee E-Mail Address\*

\*Not Required

FOR OFFICE USE ONLY

Reviewed

Examined



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

For Office Use Only
Receipt Date

# Designation of Beneficiary With Contingent Beneficiaries

**RS 5127**

(Rev. 9/14)

**THIS FORM MUST BE SIGNED, NOTARIZED AND FILED WITH THE RETIREMENT SYSTEM PRIOR TO YOUR DEATH TO BE EFFECTIVE.**

Please **PRINT** clearly, using only blue or black ink.

## Member/Pensioner Information

Registration/Retirement Number: \_\_\_\_\_

Last 4 Digits of Social Security Number\* \_\_\_\_\_

Name: \_\_\_\_\_

Former Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employed By:	Employer Address:
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### IMPORTANT INFORMATION REGARDING THIS FORM

- If you find this form is not suited to 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. If you wish to designate more beneficiaries than this form allows or to designate a Trust, Guardianship or payment under the Uniform Transfers to Minors Act please contact the Retirement System for the appropriate form.
- Attachments to your beneficiary form are **unacceptable**.
- New beneficiary forms filed will supersede any previous designation. Therefore, if you want to **add** or **delete** a beneficiary, for example a new child, you must include on the new form **all** beneficiaries you wish to designate.
- The same person or persons cannot be designated as both primary and contingent beneficiaries. We make payment to a contingent beneficiary(ies) only if **all** primary beneficiary(ies) die before you do.
- If you wish to have these benefits distributed through your estate, you should name "my estate" as beneficiary. Your estate can be named as either primary or contingent beneficiary. However, if you name your estate as primary beneficiary, you may not name any contingent beneficiary.
- This form is for designating beneficiaries to receive your ordinary death or post retirement death benefit. You may not designate beneficiaries to receive accidental death benefits. The beneficiaries entitled to receive accidental death benefits are mandated by statute.

### **Make sure that you:**

- **Complete all requested information.**
- **Sign and date the form.**
- **Have the form notarized, making sure the notary has entered the date his or her commission expires.**
- **Mail your completed form to:**  
**New York State and Local Retirement System**  
**Member & Employer Services**  
**Registration – Mail Drop 5-6**  
**110 State Street**  
**Albany, NY 12244-0001**

### **PERSONAL PRIVACY PROTECTION LAW**

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 System's inability to pay benefits the way you prefer. The System may provide certain information to participating employers. The official responsible for maintaining these records is the Director of Member & Employer Services, New York State and Local Retirement Systems, Albany, NY 12244. For questions concerning this form, please call 1-866-805-0990 or 518-474-7736.

### **\* SOCIAL SECURITY DISCLOSURE REQUIREMENT**

In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of the Social Security Account Number is mandatory pursuant to sections 11, 31, 34 and 334 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

**Please go to the reverse side of this form to designate beneficiaries, sign and date the form, and have the form notarized.**

**Do not alter this form or make stipulations. The use of correction fluid or other alterations on this form will render the designation invalid.**

**To the Comptroller of the State of New York.**

**Designation of Primary Beneficiary(ies).** I hereby name the following beneficiary(ies) to receive any ordinary death or post retirement death benefit, payable on my behalf. 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 this designation at any time.

Name \_\_\_\_\_  Male  Female

Address \_\_\_\_\_

Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_

Telephone Number \_\_\_\_\_

Name \_\_\_\_\_  Male  Female

Address \_\_\_\_\_

Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_

Telephone Number \_\_\_\_\_

Name \_\_\_\_\_  Male  Female

Address \_\_\_\_\_

Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_

Telephone Number \_\_\_\_\_

Name \_\_\_\_\_  Male  Female

Address \_\_\_\_\_

Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_

Telephone Number \_\_\_\_\_

Name \_\_\_\_\_  Male  Female

Address \_\_\_\_\_

Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_

Telephone Number \_\_\_\_\_

Name \_\_\_\_\_  Male  Female

Address \_\_\_\_\_

Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_

Telephone Number \_\_\_\_\_

**Designation of Contingent Beneficiary(ies).** If all of the designated primary beneficiaries die before I do, any ordinary death or post retirement death benefit payable on my behalf shall be paid to the following. 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. If I out-live all of these contingent beneficiaries, any benefit payable should be paid to my estate. I reserve the right to change this designation at any time.

Name \_\_\_\_\_  Male  Female

Address \_\_\_\_\_

Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_

Telephone Number \_\_\_\_\_

Name \_\_\_\_\_  Male  Female

Address \_\_\_\_\_

Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_

Telephone Number \_\_\_\_\_

Name \_\_\_\_\_  Male  Female

Address \_\_\_\_\_

Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_

Telephone Number \_\_\_\_\_

Name \_\_\_\_\_  Male  Female

Address \_\_\_\_\_

Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_

Telephone Number \_\_\_\_\_

**This form must be signed, dated and notarized in order to be valid**

Member/Pensioner Signature \_\_\_\_\_

Date \_\_\_\_\_

**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.

Notary Public Stamp

NOTARY PUBLIC (Please sign and affix stamp)