APPLICATION INSTRUCTIONS AND CHECKLIST - Public Employee Plan

Please verify the following information before submitting application packet. **Once you have turned in your application, ANY changes to the actual application page will require a new application to be completed.**

Application (required)

- ☐ Name, address, social security number, date of birth, telephone number, and employment information
- ☐ Last Working Day is the day your employment with a covered agency ends
- ☐ Effective Retirement Date. In *most* cases, this is the day after your actual last working day (or the day after your last day of used, EARNED sick or annual leave). If your account has been inactive, and/or you are not sure what retirement date to list, please contact our office.
- ☐ **The beneficiary section MUST be completed unless you choose option 5**. Please provide your beneficiary's name and address (if different than your address), social security number and date of birth. If you have more than one beneficiary, complete the "*Additional/Contingent Beneficiaries*" form. **MEMBER must sign and date form.**
- ☐ Signature by option you are selecting. If you are married, your spouse must also sign. ***APPLICATION MUST BE SIGNED IN FRONT OF A NOTARY.*** An Acknowledgment Form is attached for the notary to complete. If signatures are not notarized properly, your retirement may be delayed. **Options 2 and 2P may not be available if you have a non-spouse beneficiary. Please contact WRS for further information.**
- ☐ **IF YOU CHOOSE A SELF-FUNDED COLA ELECTION**, your original monthly benefit will be lower than if you had not selected a COLA option. Beginning on the July payroll following the second anniversary of your retirement, your monthly benefit will increase by the COLA option you selected and you will receive another COLA every July going forward.
- ☐ If you are unmarried, the Affidavit of Marital Status must be completed and signed

Acknowledgment Form (required)

- ☐ Notary must notarize both signatures on application

Birth Certification (if no birth certificate, see list for other acceptable documents) ➤➤➤

- ☐ Photocopy of your Birth Certificate
- ☐ Photocopy of your Beneficiary's Birth Certificate if you are retiring under 2, 2P, 3, or 3P

Automatic Payroll Deposit Form

- ☐ Name and social security number
- ☐ Financial Institution's name, address, telephone number
- ☐ Routing number and account number
- ☐ Signature and date
- ☐ Attach a voided check (if available)

Federal Income Tax Withholding Request Form

- ☐ Name, address, social security number
- ☐ A tax option is selected
- ☐ If Box 1 is checked,
  - ☐ Filing status
  - ☐ Total exemptions claimed
- ☐ Signature and date

Rehired Retiree Statue Acknowledgement (required)

- ☐ Signature and date

Prudential Life Insurance Form (optional) and only if enrolled in plan prior to retirement

- ☐ Name, address, social security number
- ☐ Beneficiary(ies) name, address, social security number, relationship
- ☐ If additional space is needed, please complete Additional/Contingent Beneficiary Form WRS-A7
- ☐ Signature and date
- ☐ ***If continuing Prudential, your employer must complete Employer section***

Other (if applicable)

- ☐ Check with your Health Insurance Administrator concerning insurance coverage once you retire
- ☐ Check with a representative of your 457 Deferred Compensation Plan or your 403(b) Tax Sheltered Annuity Plan for retirement options

Other Acceptable Documents for Birth Certification (photocopies please)

Group A (One Document Sufficient):
Delayed Birth Certificate
Naturalization Papers
Baptismal Record
Church Records
Family Bible Record
Census Records
Newspaper Record of Birth
Passport

OR

Group B (Three Documents Required):
Insurance Policies
Hospital Record
Physician's Record
School Records
Armed Forces Record
Birth Certificate of Child
Licenses (Driving, Hunting, Etc)
Voting Registration Record
Marriage Records
Records of Social/Fraternal Org.
Employment Records

Wyoming Retirement System
Public Employee Plan

BENEFIT OPTIONS AVAILABLE

OPTION 1 A monthly benefit during YOUR LIFETIME ONLY. Upon your death, your beneficiary would receive a lump-sum payment, if the total of the benefit paid to you is less than the total of your contributions and interest at the time you retired. This option does not provide for a monthly benefit after your death.

OPTION 2 A monthly benefit payable as long as YOU OR YOUR BENEFICIARY LIVE. Upon your death, your beneficiary would receive the same monthly benefit you had been receiving. After the death of both you and your beneficiary, if the total benefit paid is less than the total of your contributions and interest at the time you retired, a contingent beneficiary would receive a lump-sum payment. This option may not be available if you have a NON-SPOUSE beneficiary. Please contact WRS for further information.

OPTION 2P A monthly benefit payable as long as YOU OR YOUR BENEFICIARY LIVE. If your beneficiary precedes you in death, your benefit amount will "pop-up" to the option 1 amount for the remainder of your life. If you precede your beneficiary in death, your beneficiary will receive the same monthly benefit amount you had been receiving for the remainder of his/her life. No lump-sum payment will be available at the death of both you and your beneficiary. This option may not be available if you have a NON-SPOUSE beneficiary. Please contact WRS for further information.

OPTION 3 A monthly benefit payable during YOUR LIFETIME, AND AFTER YOUR DEATH, ONE-HALF THAT AMOUNT PAYABLE TO YOUR BENEFICIARY FOR LIFE. Upon your death, your beneficiary would receive one-half of the monthly amount you had been receiving for the remainder of his/her life. After the death of both you and your beneficiary, if the total benefit paid is less than the total of your contributions and interest at the time you retired, a contingent beneficiary would receive a lump-sum payment.

OPTION 3P A monthly benefit payable during YOUR LIFETIME, AND AFTER YOUR DEATH, ONE-HALF THAT AMOUNT PAYABLE TO YOUR BENEFICIARY FOR LIFE. If your named beneficiary precedes you in death, your benefit amount will "popup" to the option 1 amount for the remainder of your life. If you precede your beneficiary in death, your beneficiary will receive one-half of the monthly benefit amount you had been receiving for the remainder of his/her life. No lump-sum payment will be available at the death of both you and your beneficiary.

OPTION 4A A monthly benefit payable during YOUR LIFETIME. If your death occurs before you have received the benefit for ten years, your beneficiary would receive the same monthly benefit for the **BALANCE OF THE TEN-YEAR PERIOD**, after which the benefit ceases.

OPTION 4B A monthly benefit payable during YOUR LIFETIME. If your death occurs before you have received the benefit for twenty years, your beneficiary would receive the same monthly benefit for the **BALANCE OF THE TWENTY-YEAR PERIOD**, after which the benefit ceases.

OPTION 5 The largest monthly benefit payable during YOUR LIFETIME ONLY. It has no provisions for either a monthly benefit or a lump-sum payment to anyone after your death, regardless of the total benefits paid to you or the total of your contributions and interest at the time you retired.

SELF-FUNDED COLA FEATURE:
You may elect any of the payout options offered by WRS and combine it with a **self-funded cost-of-living adjustment (COLA)**. The way this works is you would elect a reduction to the initial amount of your benefit in exchange for either a 1%, 2% or 3% annual guaranteed increase starting on July 1st following the two-year anniversary of your retirement. Increases are compounded. This election is irrevocable even in the event of death or divorce.

Benefit amounts for Options 2, 2P, 3, 3P, and 4 A&B will be less than Option 1 since two lives are involved. The age of the beneficiary is a factor for Options 2, 2P, 3 and 3P. Option 5 is slightly larger than Option 1 since you forfeit all beneficiary rights. If you wish to have estimates for Options 2, 2P, 3, and 3P, you will need to provide our office with your beneficiary's birth date.

It is your responsibility to notify this office before the date you wish to begin receiving your monthly benefit. You will choose your option when you complete your application for retirement. ONLY ONE OPTION MAY BE SELECTED. ONCE AN OPTION IS CHOSEN AND YOU RECEIVE YOUR FIRST MONTHLY BENEFIT, YOU CANNOT CHANGE THE OPTION. IF YOU RETIRE UNDER OPTION 2, 2P, 3, OR 3P, YOU MAY NEVER CHANGE YOUR BENEFICIARY ONCE YOU RECEIVE YOUR FIRST CHECK. If your beneficiary precedes you in death, you cannot name a new beneficiary, even if you remarry. The benefit will stop after your death. If you and your beneficiary divorce, the original beneficiary will still receive the benefit after your death.

If you select a "Pop-up" option, please notify our office if your beneficiary precedes you in death so that we may adjust your monthly benefit.

All retirement checks are issued the last working day of each month. Your first benefit check will not be processed until our office has received the final contribution from your employer. A retroactive payment back to the retirement date is made with the first check, if necessary.
IF, AFTER RETIREMENT, YOU RETURN TO WORK FOR AN AGENCY COVERED BY THE WYOMING RETIREMENT SYSTEM, YOU MUST NOTIFY OUR OFFICE.

Public Employees Application for Retirement

WRS Office Use Only
RAIN ID :_____

1 Member's Name:_____ SS#:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone #:_____ Date of Birth:_____
Email Address:_____

2 Last Working Day:_____ Effective Retirement Date:_____

3 Employed by:_____ Position: _____

4 Beneficiary Information: (Lump-sum payment - Opt 1; Monthly benefit - Opt 2,2P,3,3P; 10 or 20 year certain benefit-Opt 4a or 4b)
Beneficiary's Name:_____
SS #:_____ Date of Birth:_____
Address:_____
City:_____ State:_____ Zip:_____ Relationship:_____

MORE THAN ONE BENEFICIARY?
List them on the Additional/Contingent Beneficiaries form.
Contingent beneficiaries not available with options 2P, 3P, or 5

6 Select Retirement Option and Self-Funded COLA election. ***(See* Benefit Options Available *page for a detailed description of options)***
A self-funded COLA election is available with any of the options below. An election for a self-funded COLA would give you a lower benefit initially, but starting on July 1 following the 2-year anniversary of your retirement, you would be guaranteed either a 1%, 2%, or 3% annual COLA. **Once you receive your first check, your Retirement Option and Self-Funded COLA election is irrevocable, even in the event of death or divorce.**

By signing below I as the member certify I have no promise of future employment with a covered employer of WRS.
BOTH SIGNATURES MUST BE SIGNED BEFORE A NOTARY (see page 2)

◇ **OPTION 1 - Self-Funded COLA:** *(please circle COLA election. If nothing is selected default will be 0% COLA)* 0% 1% 2% 3%
A monthly benefit during your lifetime only. A monthly benefit will not be paid after your death.

Member's Signature **Date** **Spouse's Signature** **Date**

◇ **OPTION 2 - Self-Funded COLA:** *(please circle COLA election. If nothing is selected default will be 0% COLA)* 0% 1% 2% 3%
A Full Joint and Survivor benefit payable as long as you or your beneficiary live.

Member's Signature **Date** **Spouse's Signature** **Date**

◇ **OPTION 2P - Self-Funded COLA:** *(please circle COLA election. If nothing is selected default will be 0% COLA)* 0% 1% 2% 3%
A Full Joint and Survivor benefit with a "pop-up" option for the member.

Member's Signature **Date** **Spouse's Signature** **Date**

◇ **OPTION 3 - Self-Funded COLA:** *(please circle COLA election. If nothing is selected default will be 0% COLA)* 0% 1% 2% 3%
A Joint and One-Half Survivor benefit payable as long as you or your beneficiary live.

Member's Signature **Date** **Spouse's Signature** **Date**

◇ **OPTION 3P - Self-Funded COLA:** *(please circle COLA election. If nothing is selected default will be 0% COLA)* 0% 1% 2% 3%
A Joint and One-Half Survivor benefit with a "pop-up" option for the member.

Member's Signature **Date** **Spouse's Signature** **Date**

◇ **OPTION 4 - Self-Funded COLA:** *(please circle COLA election. If nothing is selected default will be 0% COLA)* 0% 1% 2% 3%
A monthly benefit during your lifetime, with a 10 or 20 year certain payout. **Please Circle One 10 Years (4a) 20 Years (4b)**

Member's Signature **Date** **Spouse's Signature** **Date**

◇ **OPTION 5 - Self-Funded COLA:** *(please circle COLA election. If nothing is selected default will be 0% COLA)* 0% 1% 2% 3%
A monthly benefit during your lifetime only, with no beneficiary provisions. If your death occurs before all of your contributions and interest have been paid to you, the remaining funds revert to the retirement system.

Member's Signature **Date** **Spouse's Signature** **Date**

AFFIDAVIT OF MARITAL STATUS (Must be completed if you are not married)

I, _____, hereby declare that as of the date below, I am **not** married, and I am not required to provide a spouse's signature under the option I have chosen for retirement.

Member's Signature_____ Date_____

BOTH Signatures on Page 1 Must be Notarized

NOTARY ACKNOWLEDGMENT

State of _____
County of _____ } ss.

On *(date)*_____ , before me, *(notary's name)* _____ ,
personally appeared *(member's name)* _____ and
(spouse's name) _____ ,

❒ proved to me on the basis of satisfactory evidence **OR** ❒ personally known to me
to be the person(s) whose name(s) is/are subscribed to the attached document: *(please check box below)*

❒ RETIREMENT APPLICATION
❒ WITHDRAWAL OF MEMBER CONTRIBUTIONS
❒ CHANGE OF NAME/ADDRESS/BENEFICIARY FORM

dated _____ ,
and acknowledged to me that he/she/they executed the same.

WITNESS my hand and official seal.

Notary Seal

X_____
Signature of Notary Public

_____
My Commission Expires

NOTARY ACKNOWLEDGMENT

To be completed only if spouse's signature is not already notarized above.

State of _____
County of _____ } ss.

On *(date)*_____ , before me, *(notary's name)* _____ ,
personally appeared *(spouse's name)* _____ ,

❒ proved to me on the basis of satisfactory evidence **OR** ❒ personally known to me
to be the person whose name is subscribed to the attached document: *(please check box below)*

❒ RETIREMENT APPLICATION
❒ WITHDRAWAL OF MEMBER CONTRIBUTIONS
❒ CHANGE OF NAME/ADDRESS/BENEFICIARY FORM

dated _____ ,
and acknowledged to me that he/she executed the same.

WITNESS my hand and official seal.

X_____
Signature of Notary Public

_____
My Commission Expires

Notary Seal

WRS Office Use Only

Entered: _____
Verified: _____

Wyoming Retirement System
ADDITIONAL/CONTINGENT BENEFICIARIES FOR RETIREMENT
➤➤***To be included with the* Retirement Application Packet *only***➤➤

Member's Name:_____ Social Security #:_____

Address:_____

City:_____State:_____ Zip:_____

❒ *Check box if new address*

Additional Primary Beneficiary[ies] *(available with Options 1 and 4)*

(When multiple beneficiaries are designated, the lump sum payment will be made to the beneficiaries in equal shares unless otherwise specified in writing to the Wyoming Retirement System. Beneficiaries are not permitted under Option 5)

Name _____SSN _____ Relationship _____ DOB_____ %_____

Name _____SSN _____ Relationship _____ DOB_____ %_____

Name _____SSN _____ Relationship _____ DOB_____ %_____

Name _____SSN _____ Relationship _____ DOB_____ %_____

Name _____SSN _____ Relationship _____ DOB_____ %_____

Contingent Beneficiary[ies] *(available with Options 1, 2, 3, and 4)*

(You may designate one or more contingent beneficiaries. Should your primary beneficiary(ies) not survive you, the lump sum payment will be made to your contingent beneficiary(ies) as specified. Contingent beneficiaries are not permitted under Options 2P, 3P, and 5)

Name _____SSN _____ Relationship _____ DOB_____ %_____

Name _____SSN _____ Relationship _____ DOB_____ %_____

Name _____SSN _____ Relationship _____ DOB_____ %_____

Name _____SSN _____ Relationship _____ DOB_____ %_____

Name _____SSN _____ Relationship _____ DOB_____ %_____

X_____ _____
Member's Signature Date

WRS Office Use Only

Entered: _____

Verified: _____

➢➢ Beneficiary designation will apply to your Wyoming Retirement System **PENSION** account only unless otherwise indicated.

☐ Beneficiary designation also applies to the WRS-sponsored Prudential Life Insurance plan

Wyoming Retirement System
AUTOMATIC PAYROLL DEPOSIT*
(Please Print or Type)

Member's Name: _____ SSN: _____

Financial Institution Information:

Financial Institution's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone#: _____

9-Digit Bank Routing Number: __ __ __ __ __ __ __ __ __

CHECKING Account Number: _____

OR **SAVINGS** Account Number: _____

Deposit: ___☐___ 100% OR $_____ each payday

Complete section below if benefit is split between two accounts. Specify the amount to be credited to each account.

Financial Institution Information:

Financial Institution's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone#: _____

9-Digit Bank Routing Number: __ __ __ __ __ __ __ __ __

CHECKING Account Number: _____

OR **SAVINGS** Account Number: _____

Deposit: ___☐___ 100% OR $_____ each payday

Member's Signature: X_____ **Date:** _____

Please Attach Voided Check

(if available)

WRS Office Use Only

Entered: _____

Verified: _____

*Required by WRS; may be changed anytime by *written* instruction to the payroll section of WRS.

Wyoming Retirement System ◆ 6101 Yellowstone Road, Suite 500 ◆ Cheyenne, Wyoming 82002
Phone: (307) 777-7691 ◆ Fax: (307) 777-7157 ◆ http://retirement.state.wy.us

WRS-A9 Tax Form
(Revised 05/11)

Wyoming Retirement System
FEDERAL INCOME TAX WITHHOLDING

Name:_____ Social Security #:_____

Address:_____

City:_____ State:_____ Zip:_____

❒ *Check box if new address*

➤ ☐ I am retiring soon. My INITIAL withholding is as follows; **OR**

➤ ☐ I am already retired. Please CHANGE my current withholding as follows:

Please check the box(es) that apply to your tax status

1. ☐ I want to have WRS calculate my withholding based on current IRS tax tables. I realize that even though I have chosen this option, my monthly benefit may not be subject to taxation.
   - → Filing Status ***(please circle one)*** .....Married or Single
   - → Exemptions Claimed ***(please circle one)*** ...0 1 2 3 4 5 6 7 8 9 10

2. ☐ Withhold $_____ per month IN ADDITION to the amount I am currently having withheld.

3. ☐ Withhold $ _____ of my taxable benefit each month (TOTAL amount)

4. ☐ Withhold _____% (percent) of my taxable benefit each month.

5. ☐ I do NOT want federal withholding tax deducted from my retirement benefit. I understand I am liable for the payment of federal income tax on the taxable portion of my benefit. If my payments of estimated tax are not adequate, I understand I may be subjected to tax penalties under the estimated tax payment rules.

Signature X_____ **Date** _____

☐ Each January you will receive a 1099-R form (Distributions from Retirement Plans) for federal income tax purposes.

☐ You may update your tax information anytime by ***written*** instruction to the Wyoming Retirement System. If you are making a change, please return this form by the 20th of any month.

WRS Office Use Only

Entered: _____

Verified: _____

Wyoming Retirement System ◆ 6101 Yellowstone Road, Suite 500 ◆ Cheyenne, Wyoming 82002
Phone: (307) 777-7691 ◆ Fax: (307) 777-7157 ◆ http://retirement.state.wy.us

Wyoming Retirement System
REHIRED RETIREE STATUTE ACKNOWLEDGEMENT

►MUST BE COMPLETED◄

To protect the actuarial integrity of the Wyoming Retirement System, Rehired Retiree statutes have been established. This form acknowledges that you have been informed of the requirements if you return to work; it in no way implies you will return to work for a covered agency.

Member Name: _____ SS#:_____

I understand I must terminate employment with all covered agencies before I am eligible to retire. Once I retire, if I am rehired by an employer covered under the same plan of WRS, in ***what would normally be a full-time, contributing position (working at least 86 hours or more per month)***, I must comply with the statutes regarding Rehired Retirees. Within 30 days of my re-employment date, I must notify WRS of my decision to either:

1) **Discontinue** my retirement allowance and be reinstated as a contributing member of WRS, if I meet the definition of Wyoming Statute 9-3-402(a)(vii); OR

2) **Continue** to receive my retirement allowance and not be reinstated as a contributing member of WRS if I meet the criteria outlined in Wyoming Statute 9-3-415(g) regarding rehired retirees. **I understand I must have at least a 30-day break in service AND my employer must submit my final contributions to WRS before I can return to work for a covered employer.** If I return to work for a covered employer and continue to receive my retirement allowance, my employer must agree to pay the rehired retiree fee equal to both the member and employer's contributions required by law (if applicable). I know I will not receive credit for the period of my second employment and contributions will not be withheld from my wages. **I understand if either my employer or I do not follow the rehired retiree law, the board shall immediately cancel my retirement benefit and I will be reinstated as a contributing member of WRS.**

X_____ _____
Signature of Member Date

➤➤➤➤*BEFORE YOU RETIRE, REMEMBER TO:*

- **Check with your HEALTH INSURANCE ADMINISTRATOR for information regarding insurance coverage once you retire; WRS does not provide retiree health insurance**
- **Check with a representative of your 457 DEFERRD COMPENSATION PLAN or your 403(b) TAX SHELTERED ANNUITY PLAN to ensure you understand all your options**

WRS Office Use Only

Entered: _____

Verified: _____

PRUDENTIAL LIFE INSURANCE

IF YOU ARE NOT CURRENTLY ENROLLED, DO NOT COMPLETE THIS FORM

Name: _____ SS#: _____

Address: _____

City: _____ State:_____ Zip: _____

❒ *Check box if new address*

If you are **currently** participating in the Prudential Life Insurance program and want to continue your Prudential coverage in retirement, please complete the following information.

☐ YES, I want to continue having the Prudential Life Insurance premium deducted from my retirement check ***(Please take this to your Employer to complete section below)***

☐ NO, I do not want to continue the Prudential Life Insurance

If YES, please provide your beneficiary information below:

Beneficiary's Name: _____

Beneficiary's Address: _____

_____

Beneficiary's Social Security Number: _____

Relationship to Member: _____

Signature: X_____ **Date:**_____

TO BE COMPLETED BY EMPLOYER:

Employer ID#: _____ Employer Name: _____

Employee's last working day _____

Did Employee have Prudential Life Insurance offered through WRS? ❒ Yes ❒ No

If yes, amount of premium: ❒ $16.00 ❒ $12.00 ❒ $9.00

Final premium will be paid on _____ in the amount of $_____
(date)

- *If you are under 60 years of age, become totally disabled (as determined by Prudential), and have been disabled for at least nine (9) months, your Schedule of Benefits for Group Decreasing Term Life Insurance may be continued without further contributions as long as you annually furnish proof of your continued disability satisfactory to Prudential. For information about applying for a Waiver of Premium, call HealthSmart Benefit Solutions, Inc. at 800-525-8056. The Waiver of Premium does not apply to dependent spouse, domestic partner, or child coverage.*
- *If you do not know if you are enrolled, check your pay stub for a $9.00, $12.00, or $16.00 Prudential deduction or contact your payroll clerk.*

WRS Office Use Only

Entered: _____

Verified: _____