

**Paid Fireman Pension Fund - Plan A**  
**Application for Retirement**

Print or Type:

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

Check box if new address

Original Employment Date: \_\_\_\_\_ Last Working Day: \_\_\_\_\_

Benefit to Begin: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**WORK HISTORY** as firefighter (past to present)

(1)Employer: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

(2)Employer: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

(3)Employer: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Employment Verified by: X \_\_\_\_\_

Signature of Department Head

Upon your death, your spouse will receive a lifetime monthly benefit equal to 100% of your monthly benefit.

**Spouse Information:**

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

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**List Unmarried Children under age 18:**

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

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

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

Member's Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

**\*\* MEMBER'S BIRTH CERTIFICATE  
MUST ACCOMPANY APPLICATION \*\***

<i>WRS Office Use Only</i>	
Entered: _____	_____
Verified: _____	_____

## BIRTH CERTIFICATION

**If you do not want to send copies of your birth records**, administrators and supervisors are authorized to examine the documents and certify by signing below. *Documents from Group A submitted for examination must show the date of birth of the member and survivor (if applicable). Documents from Group B must show the date of birth or age and date the document was executed.*

### To be Completed by Administrator or Supervisor

Member's Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Employed by: \_\_\_\_\_

Member's Date of Birth: \_\_\_\_\_

Title of Document Presented	Date Document was Executed	Date of Birth or Age Shown on Document	Is Document Original, Certified Copy, Photocopy?

Survivor's Name: \_\_\_\_\_

( For Options 2, 2P, 3, 3P) Survivor's Date of Birth: \_\_\_\_\_

Title of Document Presented	Date Document was Executed	Date of Birth or Age Shown on Document	Is Document Original, Certified Copy, Photocopy?

I hereby certify that the documents shown above were presented to me by the employee named, and that said documents were, in my opinion, valid instruments, and the birth dates recorded hereon are as they appeared on said documents.

X

Date
Administrator's Signature
Title

If a birth certificate is not available, please submit records of your birth using the following documents as proof of age. Do not send originals or certified copies; photocopies are requested.

- |   |  |
|---|--|
| <p><b>Group A (One Document Sufficient):</b></p> <ul style="list-style-type: none"> <li>Delayed Birth Certificate</li> <li>Naturalization Papers</li> <li>Baptismal Record</li> <li>Church Records</li> <li>Family Bible Record</li> <li>Census Records</li> <li>Newspaper Record of Birth</li> <li>Passport</li> </ul> | <p><b>Group B (Three Documents Required):</b></p> <ul style="list-style-type: none"> <li>Insurance Policies</li> <li>Hospital Record</li> <li>Physician's Record</li> <li>School Records</li> <li>Armed Forces Record</li> <li>Birth Certificate of Child</li> <li>Licenses (Driving, Hunting, Etc)</li> <li>Voting Registration Record</li> <li>Marriage Records</li> <li>Records of Social/Fraternal Org.</li> <li>Employment Records</li> </ul> |
|---|--|

WRS Office Use Only

Entered: \_\_\_\_\_

Verified: \_\_\_\_\_

**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)

<i>WRS Office Use Only</i>
Entered: _____
Verified: _____

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

**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: _____

**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: \_\_\_\_\_