



APPLICATION FOR SERVICE RETIREMENT

(Must be submitted prior to or on the date of retirement)

ALAMEDA COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

475 14th Street, Suite 1000, Oakland, CA 94612-1900

Telephone: 510-628-3000 or 1-800-838-1932 Fax: 510-268-9574

Website: www.acera.org



SECTION I: GENERAL INFORMATION – PLEASE TYPE OR PRINT

Name: _____ Date of Birth: _____ Last 4 SSN: XXX-XX-_____

Address: _____ City/State/Zip Code: _____

Home Email Address: _____ Receive ACERA news to your email address: Yes ___ No ___

Home Phone No.: _____ Cell Phone No.: _____ Work Phone No.: _____

Department: _____ Dept. No.: _____ Position: _____

My last day on the job will be _____ and my first day in retirement will be _____

I estimate my total service credit to be _____

Are you aware of any pending administrative appeal, arbitration/settlements? Yes _____ No _____

I understand that if I appeal my termination of employment (e.g., grievance, arbitration, court proceeding) and I retire at any time (e.g., prior to resolution of the appeal), my retirement will be irrevocable and I may not be reinstated to my previous employment. _____ (initials). I understand and elect to retire with this knowledge. _____ (initials).

SECTION II: RECIPROCITY, IF APPLICABLE

If you have established reciprocity with ACERA and another retirement system, you must retire concurrently and apply a separate application with each agency. The length of time it takes to process your retirement application depends on when ACERA receives the necessary information from the other agency.

Name of Reciprocal Agency: _____

Current Status (i.e., Active, Deferred, Retired) with Reciprocal Agency: _____

Date of Retirement with Reciprocal Agency: _____ Other Established Reciprocal Agencies: _____

SECTION III: MARITAL STATUS

Please provide a copy of birth certificate, marriage certificate/state-registered certificate, and social security card for person below.

Current Marital Status: Married Divorced * Single Widowed Date of Marriage: _____

Name of Current Spouse or State-Registered Domestic Partner: _____

Social Security Number of Current Spouse or State-Registered Domestic Partner: XXX-XX-_____

Date of Birth of Current Spouse or State-Registered Domestic Partner: _____

Address: _____ City/State/Zip Code: _____

**Divorced members (or terminated domestic partner) must submit final judgment (all pages) for legal review, if divorce (or termination of domestic partnership) occurred during your ACERA membership. ACERA may require member to submit additional documents in connection with divorces prior to finalization of your retirement benefit and payment of your monthly allowance. ACERA will not process 100% payment without conclusion of ACERA's legal department review. Final judgments do not need to be submitted if divorce was prior to your date of entry with ACERA.*

SECTION IV: Please complete and submit the necessary forms and documents for your deductions

- I elect to enroll myself in an ACERA-sponsored health plan. My health plan is _____
- I elect to enroll my spouse and eligible dependents in my health plan.
- I do not wish to elect/enroll in ACERA's sponsored medical plan.
- I elect to be a retiree member of: ACRE REAC

I authorize deductions from my monthly retirement allowance for the following items:

- Medical Plan Delta Dental Plan Vision Plan 1st United Services C.U. (obtain form from Credit Union)
- Life Insurance (not all policies are eligible) Federal Income Tax (Attach W-4) State Income Tax (Attach DE-4P)

SECTION V: AUTOMATIC BANK DEPOSIT AUTHORIZATION - DIRECT DEPOSIT

**Note: As of July 1, 2008, direct deposit is mandatory. In addition, ACERA will not deposit member's monthly retirement allowance payable to a bank account in the name of a trust.*

Pursuant to Cal. Gov. Code Sec. 31452.6 and 7480, I hereby authorize my Financial Institution to disclose to ACERA, at any time, the following information: (1) name and address of any co-owners, co-signer, or any other person who had access to funds in my account; and (2) the name and address of person who closed my account. I hereby authorize the deposit of my retirement benefits to the Financial Institution indicated below, to credit the amounts thereof to my:

Bank Name: _____ Checking Account Savings Account

Address: _____

NOTE: Please provide a VOIDED CHECK. If you are selecting a savings account, please attach a savings account statement or a certified letter from the bank.

ACCOUNT NO.: _____ ABA ROUTING NO.:

SECTION VI: Beneficiary for Continued Monthly Payments (Continuance) If Any

I am naming a beneficiary for continued monthly payments (continuance), if any (if not, please leave it blank):

Name: _____ Date of Birth: _____
Address: _____ Last 4 SSN: XXX-XX-_____
City, State, Zip Code: _____ Relationship: _____
Telephone Number: _____ Email Address: _____

IF YOU ARE NAMING A MINOR, READ THIS: If a beneficiary is a minor and you wish to name an adult to receive and manage payments for the minor without court appointment or court supervision until an age you choose, use this format to name the beneficiary: *[Name of adult] as custodian for [Name of minor] until age [choose a number at least 18 but not more than 25] under the California Uniform Transfers to Minors Act.* Use the adult's address and telephone number and the minor's date of birth, social security number, and relationship. Alternatively, you may simply name the minor as beneficiary without naming a custodian, in which a case court appointment and supervision of a guardian will be required before any payments can be distributed; otherwise, all funds will be distributed to the beneficiary at age 18.

In order to nominate a beneficiary for a continuance under Options 2, 3, or 4 pursuant to Government Code Section 31760.2, 31760.3 or 31760.4, the person(s) so designated must have an insurable interest in your life. Documentation, for example, proof of birth that an insurable interest exists is required for all non-related persons and family members.

- Only Option 4 allows for more than one continuance beneficiary. If you are electing Option 4 and wish to name additional beneficiaries, check this box and provide the information listed above on additional sheets, titled "Section VII Additional Beneficiaries." Please indicate the percentage for each beneficiary next to their name.

SECTION VII: Beneficiary for Lump-Sum Benefits

As an ACERA retiree, you will have certain benefits that will be paid at the time of your death. In this Section, you are naming beneficiaries for all lump-sum benefits, including but not limited to the following:

- 1. One thousand dollar (\$1,000) death benefit;
- 2. Retirement allowance, if any, earned but not yet paid to you at the time of your death;
- 3. Refund of excess contributions if, when all monthly retirement payments have been made, the total payments made by ACERA are less than your total contributions and interest; and
- 4. Refund of any prepaid health insurance premiums for dependents not yet applied at the time of your death.

NOTE: To name different beneficiaries for different benefits, use a separate beneficiary form. In addition, indicate the percentage of benefit (total should not exceed 100%) for each beneficiary. If you do not indicate a percentage, payment will be divided in equal shares to the named beneficiaries.

Unless you provide otherwise, if you name multiple primary beneficiaries, in the event primary beneficiaries have pre-deceased you, ACERA shall pay surviving primary beneficiaries in equal shares.

PRIMARY BENEFICIARY

Name: _____
Address: _____
City, State, Zip Code: _____
Telephone Number: _____
Email Address: _____

Percentage of Benefit: _____
Date of Birth: _____
Last 4 SSN: _____
Relationship: _____

Name: _____
Address: _____
City, State, Zip Code: _____
Telephone Number: _____
Email Address: _____

Percentage of Benefit: _____
Date of Birth: _____
Last 4 SSN: _____
Relationship: _____

If no primary beneficiary survives you, we will pay these benefits to the contingent beneficiaries named below.

Unless you provide otherwise, if you name multiple contingent beneficiaries, in the event contingent beneficiaries have pre-deceased you, ACERA shall pay surviving contingent beneficiaries in equal shares.

CONTINGENT BENEFICIARY

Name: _____
Address: _____
City, State, Zip Code: _____
Telephone Number: _____
Email Address: _____

Percentage of Benefit: _____
Date of Birth: _____
Last 4 SSN: _____
Relationship: _____

Name: _____
Address: _____
City, State, Zip Code: _____
Telephone Number: _____
Email Address: _____

Percentage of Benefit: _____
Date of Birth: _____
Last 4 SSN: _____
Relationship: _____

SECTION VIII: Signature of Member's Spouse or Domestic Partner

I am the spouse or state-registered domestic partner of the ACERA member who is submitting this designation of beneficiaries. I understand that the sole purpose of this section is to notify the current spouse or state-registered domestic partner of the selection of benefits or change of beneficiary made by a member. It is not intended to be "consent," "waiver," or "a transmutation agreement" regarding the transfer of community property interest/assets of the signing spouse or state-registered domestic partner.*

Name of Spouse or State-Registered Domestic Partner; please print: _____

Spouse's or State-Registered Domestic Partner's Signature: _____ Date: _____

* See California Probate Code Sec 140, et. seq. ; California Probate Code Sec 5021, et. seq; California Family Code Sec. 850, et. seq.

SECTION IX: Declaration of Reason for Absence of Spouse's or Domestic Partner's Signature

I declare under penalty of perjury under the laws of the State of California that:

- I am not married or registered with the Secretary of State under a domestic partnership.
- I am a widower and have not remarried.**
- My current spouse or domestic partner has no identifiable community property interest in any ACERA benefits earned through my employment.
- I do not know, and have taken reasonable steps to determine, the whereabouts of my current spouse or domestic partner.
- My current spouse or domestic partner has been advised of this designation of beneficiaries and has refused to sign the written acknowledgment.
- My current spouse or domestic partner is incapable of executing the written acknowledgment because of an incapacitating mental or physical condition.
- My current spouse or domestic partner and I have executed a marriage or domestic partnership settlement agreement pursuant to California Family Code §§1500-1620 that makes the community property law inapplicable to our marriage or domestic partnership.

Member's Signature: _____ Date: _____

**Equivalent to 31760.3(a)

SECTION X: Notice and Acknowledgement

In accordance with the County Employees Retirement Law of 1937, I hereby apply for retirement from active service. I understand that any changes in the above beneficiary designations cannot be effective until received by ACERA in writing.

I hereby confirm the beneficiary designations shown on this form. I hereby grant and authorize ACERA to reduce the death benefit payable to my designated beneficiaries by any and all amounts owed to ACERA upon my death.

Effective January 1, 2016, ACERA members who are eligible to retire for service retirement and do so when an application for disability retirement is pending may change the type of retirement allowance the member selected at the time of service retirement, and select alternate retirement allowance *if* the member is awarded a disability retirement.

I further understand that in the event an error is discovered after the finalization of my retirement calculations, I am obligated to reimburse ACERA of any overpayment plus interest.

I am advised that I may not return to work based on a verbal or written pre-arrangement of any kind. I am also advised that I am not permitted to return to work without reinstatement to active ACERA membership and termination of my retirement allowance, until 180 days for general members, and 90 days for safety members. I am also advised that only former ACERA public safety members *may* be subject to fewer restrictions under ACERA's policy and/or the law. Assuming compliance with ACERA's policy and/or the law, as an ACERA retiree returning to serve an ACERA Participating Employer, I may not work more than 960 hours in a fiscal year, without reinstatement to active ACERA membership and termination of my retirement allowance. I understand that labeling my work as a retiree as a consultant, or independent contractor is not determinative of whether or not my work will be in violation of ACERA's policy and/or the law. I understand it is my duty to ensure that my return to work as an ACERA retiree is not in violation of ACERA's policy and/or the law.

I am aware that violation of ACERA's policy and/or applicable law(s), including but not limited to working more than 960 hours in a fiscal year, or returning to work without the appropriate break in service, may result in the following:

1. Reinstatement of my active ACERA membership;
2. My reimbursement to ACERA of all retirement allowances paid during the period or periods of employment that are in violation of ACERA's policy or applicable law(s);
3. My reimbursement to ACERA of any monthly Medicare Part B premium, medical, dental, and vision allowances paid to me and the administrative expenses incurred in connection with a fact-finding investigation, audit, and other expenses in connection with responding to the matter of unlawful employment;
4. Other consequences not currently foreseen, but applicable under the law.

I understand that the County Employees' Retirement Law of 1937, as amended, provide that it is unlawful to make or cause to be made, or present any knowingly false material statement or material misrepresentation, to knowingly fail to disclose a material fact, or otherwise provide false information with the intent to use it, or allow it to be used, to obtain, receive, continue, increase, and deny or reduce any benefit to any person. I further understand that it is unlawful to knowingly accept or obtain payment from a retirement system with knowledge that the recipient is not entitled to the payment and to retain the payment for personal use or benefit.

Member's Signature: _____

Date: _____

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Forms: (Available on ACERA Website)

- Application for Service Retirement
- Direct Deposit Form (include voided check or letter from bank with Account # & Routing #)
- Authorization to Pay 80% Retirement Allowance Form
- Tax Withholding Designation Form (IRS Federal Form W-4P)
- Tax Withholding Designation Form (EDD State of California/Withholding Certificate for Pension or Annuity Payment)
- ACERA Medical Enrollment Form
- ACERA Dental Plan Enrollment Form
- ACERA Vision Plan Enrollment Form
- Affidavit of Dependent Eligibility Form (If covering dependent(s) age 19-26)
- Medicare Part B Reimbursement Plan (MBRP) Application Form (Enrollment in Medicare Part B and 10 years of service required)
- Kaiser Senior Advantage Medical Form (Member/Spouse)
- Member Enrollment Questionnaire (MEQ)
- Address/Name Change Request Form / Statement of Name Change

Documents: Member (and or State Registered Domestic Partner or Spouse generated)

- Copy of Member Birth Verification (for all members)
- Copy of Marriage License or State Registered Domestic Partnership (If Continuance)
- Copy of Spouse/Dependent(s) Birth Verification (If Continuance)
- Copy of Spouse/Dependent(s) Social Security Card (If Continuance)
- Copy of Domestic Relationship Order (DRO), Joinder and/or Notice of Termination of Domestic Partnership (If during ACERA membership)
- Copy of Signed Medicare Card with Part B (If electing health care benefits)
- Health Care Dependent Summary or Open Enrollment Statement (If covering dependent(s))
- COBRA Proof of Coverage (If electing health care benefits)

Members often assume that ACERA and their employers share information. This is not the case given laws surrounding confidentiality, health records, and personnel records. Therefore, members must submit the information applicable to them prior to or at the time of retirement.

Failure to submit any of the above documents prior to or at the same time as submitting application for retirement shall delay the processing of my retirement benefits.