



Member Enrollment Questionnaire

Alameda County Employees' Retirement Association

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

Phone: 510-628-3000 Fax: 510-268-9574 QIC: 22901 Email: info@acera.org Website: www.acera.org



Providing the following information is required by law. Please complete this questionnaire and send it to ACERA via email, fax, QIC, or mail. By entering an email address below, or if your email address has been provided by your employer, you are authorizing ACERA to send all future communications via email. You are required to furnish evidence of birth verification. ACERA accepts photocopies of the following:

- Certified birth certificate or official report of birth abroad
- Valid foreign passport with valid record of arrival/departure (Form I-94)
- Official US passport or official passport issued from a US territory
- Passport Card or REAL ID
- Official naturalization certificate

Not acceptable as proof of birth: Driver's license and California identification

Section 1: Member Information (Please Print)

Name: _____ Birth Date: _____ SSN: _____

Address/City/State/Zip: _____

Other Names Used: _____ Phone: _____ Email: _____

Marital Status: Single: Married: Divorced: Widowed: State Registered Domestic Partner:

Spouse/State Registered Domestic Partner Information

Name: _____ Birth Date: _____ SSN: _____

Date of Marriage/State Registration: _____ County: _____

Date of Divorce/Termination of Domestic Partnership: _____ County: _____

Section 2: Employer Certification

When enrolling an employee in ACERA membership, the Participating Employer certifies that (a) the individual is an employee of the Participating Employer; (b) the employee's position is eligible for membership with ACERA; (c) the employee works in a full-time permanent position; and (d) the employee should be enrolled in ACERA. The Employer's act of electronically transmitting the aforementioned information, which by ACERA Membership policy is necessary for the enrollment of a new member, fulfills the Employer's certification requirements.

Section 3: Previous Employment

It is important that ACERA is aware of your prior public plan benefits in order to enroll you in the appropriate ACERA plan as a new or re-entering member of the retirement system; prior service could also affect your contribution rate.

Prior to your new permanent employment, were you ever a permanent or temporary employee of Alameda County, Alameda County Superior Courts, Alameda County First 5, Alameda County Housing Authority, Alameda Health System (formerly Alameda County Medical Center), Office of Education, and Livermore Area Recreation and Park District (LARPD)? Yes* No

Are you currently or were ever employed by the State of California or any other county, city, or public agency in California (not including the federal government)? Yes* No

Are you currently or were you ever a member of any other public retirement system? Yes* No Funds still on deposit? Yes* No

* If your answer is yes to any of the above questions, please provide information on all departments or agencies where you were previously employed, whether it was temporary or permanent employment, and any other names used: _____

Establishing Reciprocity – If you wish to establish reciprocity, please complete the below section. ACERA will begin the certification process with your prior agency. To learn more on eligibility rules and the benefits of establishing reciprocity, please visit our web site at www.acera.org/establishing-reciprocity.

I ELECT to establish reciprocity, if eligible, with my previous employer's retirement system(s). I understand that this election is irrevocable and I cannot withdraw contributions from the prior reciprocal retirement system(s) unless I terminate from ACERA. List all previous employer's retirement system(s) here: Agency: _____ Dates of Service: _____ to _____
Agency: _____ Dates of Service: _____ to _____

I DO NOT ELECT to establish reciprocity with my previous employer's retirement system(s).

Section 4: Beneficiary Designation for ACERA Death Benefits

A beneficiary is a person you designate—who does not predecease you—to receive your ACERA death benefits should you pass away. You can name one or more beneficiaries below. If your beneficiary predeceases you, your signature below is an instruction to ACERA to pay the remaining named beneficiaries as if the predeceased beneficiary was not named. Use a blank page if you need more space—be sure to state the type of beneficiary (e.g., primary or contingent).

If You Are Naming A Minor: (A) You can 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 18 to 25] under the California Uniform Transfers to Minors Act.” Use the adult’s name/address/telephone and minor’s date of birth; or (B) You can name the minor. In such cases a court appointment of a guardian will be required or all funds will be distributed to the beneficiary at age 18.

If you do not designate a beneficiary on this document, ACERA will pay all applicable death benefits in accordance with law. Such payments may be made, depending on the circumstances, to your probate estate, to your trust, or directly to your beneficiaries either named in your will or pursuant to the laws of intestate succession.

Primary Beneficiary

Percent of Benefit lines must total 100%. If you do not indicate a percentage, or if the percentages do not equal 100%, ACERA shall pay surviving beneficiaries in equal shares.

Name: _____ Percentage of Benefit: _____ %
Address: _____ Birth Date: _____
City/State/ZIP: _____ SSN: _____
Phone: _____ Email: _____ Relationship: _____

Name: _____ Percentage of Benefit: _____ %
Address: _____ Birth Date: _____
City/State/ZIP: _____ SSN: _____
Phone: _____ Email: _____ Relationship: _____

Contingent Beneficiary

If no primary beneficiary survives you, we will pay death benefits to the contingent beneficiaries named here. Percent of Benefit lines must total 100%. If you do not indicate a percentage, or if the percentages do not equal 100%, ACERA shall pay surviving beneficiaries in equal shares.

Name: _____ Percentage of Benefit: _____ %
Address: _____ Birth Date: _____
City/State/ZIP: _____ SSN: _____
Phone: _____ Email: _____ Relationship: _____

Name: _____ Percentage of Benefit: _____ %
Address: _____ Birth Date: _____
City/State/ZIP: _____ SSN: _____
Phone: _____ Email: _____ Relationship: _____

I understand the rights and claims of an eligible surviving spouse or state registered domestic partner to receive a monthly survivor allowance, if eligible, may be superior to and supersede the rights and claims of any other beneficiary named above. I declare the above to be true, correct, and accurate under penalty of perjury, under the laws of the State of California. I make the above statements with the understanding that ACERA will rely upon them for the purpose of determining retirement plan eligibility, the establishment of reciprocity and eligible benefit payments. I hereby agree to notify ACERA immediately of any changes to the above facts and information.

MEMBER SIGNATURE: _____

DATE: _____