NON-MEMBER RETIREMENT ALLOWANCE APPLICATION

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: _____ Social Security Number _____-_____-_____

Street Address: _____ City/State/Zip Code:_____

Home Phone No.: (____)_____ Cell Phone No.: (____)_____ Email Address (permanent): _____

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:_____

Dependent:_____ Date of Birth:_____ Dependent:_____ Date of Birth:_____

Dependent:_____ Date of Birth:_____ Dependent:_____ Date of Birth: _____

Effective Date of Allowance: _____
(Date must be prospective, but within 60 days or date of receipt at ACERA)

SECTION II: EX-SPOUSE OR FORMER STATE-REGISTERED DOMESTIC PARTNER:

ACERA Member - Name of Ex-Spouse or Former State-Registered Domestic Partner: _____

ACERA Member - Social Security Number of Ex-Spouse or Former State-Registered Domestic Partner: _____

SECTION III: DEDUCTIONS

☐ I elect to enroll myself in an ACERA-sponsored health plan. My current 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 authorize deductions from my monthly retirement allowance for the following items:

☐ Medical Insurance ☐ Federal Income Tax (Attach W-4P) ☐ State Income Tax (Attach DE-4P)

☐ Dental Insurance ☐ Vision Insurance ☐ 1st United Services Credit Union ☐ Retirement Association Dues

SECTION IV: 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 the name and address of any co-owner, co-signer, or any other person who had access to funds in my account following the date of my death or, if the account has been closed, the name and address of the person who closed the account.

I hereby authorize automatic monthly deposits of my retirement benefits by electronic fund transfer to the Financial Institution indicated below:

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 V: BENEFICIARY DESIGNATIONS

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

1. Retirement allowance, if any, earned but not yet paid to you at the time of your death;
2. 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
3. Refund of any prepaid health insurance premiums for dependents not yet applied at the time of your death.

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 phone 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 and all funds will be distributed to the beneficiary at age 18.

NOTE: To name different beneficiaries for different benefits, use a separate beneficiary form to be provided by ACERA for that purpose. 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: _____ _____ Percentage of Benefit: _____
Address: _____ Date of Birth: _____
City, State, Zip Code: _____ Social Security No.: _____
Telephone Number: (_____)_____ Relationship: _____
Email Address:_____

Name: _____ Percentage of Benefit: _____
Address: _____ Date of Birth: _____
City, State, Zip Code: _____ Social Security No.: _____
Telephone Number: (_____)_____ Relationship: _____
Email Address:_____

Name: _____ Percentage of Benefit: _____
Address: _____ Date of Birth: _____
City, State, Zip Code: _____ Social Security No.: _____
Telephone Number: (_____)_____ Relationship: _____
Email Address:_____

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: _____ Percentage of Benefit: _____
Address: _____ Date of Birth: _____
City, State, Zip Code: _____ Social Security No.: _____
Telephone Number: (_____)_____ Relationship: _____
Email Address:_____

Name: _____ Percentage of Benefit: _____
Address: _____ Date of Birth: _____
City, State, Zip Code: _____ Social Security No.: _____
Telephone Number: (_____)_____ Relationship: _____
Email Address:_____

Name: _____ Percentage of Benefit: _____
Address: _____ Date of Birth: _____
City, State, Zip Code: _____ Social Security No.: _____
Telephone Number: (_____)_____ Relationship: _____
Email Address:_____

SECTION VI: SIGNATURE

In accordance with the County Employees Retirement Law of 1937, I hereby apply for a retirement allowance. I understand that any changes in the above elections 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 beneficiary by any and all amounts owed to ACERA upon my death.

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.

Non-Member's Signature: _____ Date: _____