PERF INDIANA Membership Record

State Form 34413 (R6/09-04)

PRIVACY NOTICE

All Social Security Numbers are requested by this agency in accordance with the requirements of the Internal Revenue Code. Disclosure is mandatory and this form will not be processed without this information.

INSTRUCTIONS:
1) Please print or type in black ink.
2) Complete all information. Incomplete forms will be returned.
3) Return the completed and signed form directly to PERF. ***Do not return the instruction pages.***
4) DO NOT FAX. Facsimile copies are not acceptable.

Help and Reset buttons are found at the bottom of each page. Yellow boxes will not print

STEP 1: ENROLLMENT INFORMATION

Social Security Number		Date of Birth (mm/dd/yyyy)
First Name	MI	Last Name
Address		
City	State IN	Zip Code
Home Telephone Number		Other Telephone Number
E-mail Address		

GENDER ☐ MALE ☐ FEMALE

CURRENT MARITAL STATUS ☐ SINGLE ☐ MARRIED

STEP 2: For Employer Use Only

Date of Full-time Employment in this PERF-covered Position, and start of Mandatory Contributions (mm/dd/yyyy)

Position or Title

Is this an Elected Position? ☐ **YES** ☐ **NO**

Has this employee ever been a member of PERF before? ☐ **YES** ☐ **NO**

Employer Name		Employer Phone Number
Employer Address		
City	State IN	Zip Code
Employer Account Number		Title of Authorized Agent

I have verified that the Social Security Number on this form is the same as the number used on our payroll and reported to the Internal Revenue Service for tax purposes.

Signature of Authorized Agent	Printed Name of Authorized Agent

Sample Form | Written Instruction | Video Instruction | Reset Form

Save | Print

Member Name *(Last, First, Middle Initial)*	Social Security Number

STEP 3: BENEFICIARY INFORMATION (Must be Signed and Dated by the Member)

Attach Additional Copies of this Page if Necessary

Additional pages are attached. ☐ **YES** ☐ **NO**

Primary Beneficiary or Beneficiaries

Beneficiary Name (Last, First, Middle Initial)	Social Security Number or Tax ID		
Date of Birth (*mm/dd/yyyy*)	Relationship to Member		
Street Address	City	State	Zip Code

Beneficiary Name (Last, First, Middle Initial)	Social Security Number or Tax ID		
Date of Birth (*mm/dd/yyyy*)	Relationship to Member		
Street Address	City	State	Zip Code

Contingent Beneficiary or Beneficiaries

Beneficiary Name (Last, First, Middle Initial)	Social Security Number or Tax ID		
Date of Birth (*mm/dd/yyyy*)	Relationship to Member		
Street Address	City	State	Zip Code

Beneficiary Name (Last, First, Middle Initial)	Social Security Number or Tax ID		
Date of Birth (*mm/dd/yyyy*)	Relationship to Member		
Street Address	City	State	Zip Code

In accordance with the provisions of Indiana Code § 5-10.2-3, I designate my beneficiary or beneficiaries of my Annuity Savings Account as shown above. I understand that this designation of beneficiary supersedes and replaces any prior designation of beneficiary or beneficiaries that may have been made in the course of this or any prior employment in a PERF-covered position with any other employer. If the primary beneficiary or beneficiaries herein designated survive me, they shall receive the funds, if any, that are payable by the fund to a designated beneficiary. If the primary beneficiary or beneficiaries do not survive me then the contingent beneficiary or beneficiaries shall receive such funds. If none survive me, then the beneficiary shall be my estate. If no designation is made, any death benefit due would be payable to my estate.

I reserve the right to change the primary or contingent beneficiaries at any time prior to retirement by filing a Change of Beneficiary form with the Board of Trustees of the Fund. Such a change must be received and accepted by the fund for it to become effective.

Signature of Member	Printed Name	Date