

EMPLOYEES' RETIREMENT SYSTEM OF RHODE ISLAND
 40 Fountain Street, 1st Floor
 Providence, RI 02903 – 1854
 Office (401) 222-2203, Fax (401) 222-2430

APPLICATION FOR REFUND OF ACCUMULATED CONTRIBUTIONS TO MEMBER

Instructions: Please print or type in black ink. See reverse side for additional information.

RETIREMENT PLAN (CHECK ONE) State/Teachers Municipality State Police Judges

MEMBER INFORMATION

SOCIAL SECURITY NUMBER		DATE OF BIRTH(mm/dd/ccyy)	
FIRST NAME	MI	LAST NAME	
ADDRESS		HOME PHONE:	
		BUSINESS PHONE:	
CITY	STATE	ZIP	

MOVING WITHIN THREE (3) MONTHS?

Provide new address and date of address change. If no date of address change is provided, the above address will be used.

ADDRESS

CITY	STATE	ZIP	EFFECTIVE DATE (mm/dd/ccyy) / /
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LUMP SUM DISTRIBUTION ELECTION (Check one)

A. <input type="checkbox"/>	The Employees' Retirement System is directed to make full payment to me, less applicable mandatory Federal tax withholding.
B. <input type="checkbox"/>	100% Direct Rollover/Transfer. The Employees' Retirement System is directed to mail the taxable portion of my distribution to my Trustee/Custodian who has signed the Agreement of Trustee/Custodian. The non-taxable distribution, if any, will be mailed to the above address.
C. <input type="checkbox"/>	Partial Direct Rollover/Transfer. The Employees' Retirement System is directed to mail 100% of my taxable distribution to my Trustee/Custodian(s) who has/have signed the Agreement of Trustee/Custodian. _____ % will be sent to Trustee/Custodian _____, and _____ % will be sent to Trustee/Custodian _____. The non-taxable distribution, if any, will be mailed to the above address.

If Option B or C was chosen, your Trustee/Custodian(s) must complete the "Agreement of Trustee/Custodian" form.

OPTIONAL ADDITIONAL FEDERAL TAX WITHHOLDING (If A was chosen above.)

In addition to the mandatory Federal tax withholding, I desire to have additional Federal tax withheld from the taxable distribution in the amount of \$_____.

SIGNATURE (This section must be signed by member.)

In consideration of the return of my accumulated contributions, I do hereby waive and relinquish for myself, my heirs and my assigns, all accrued vested rights in the system. I also understand that all creditable service is forfeited by acceptance of said refund.

SIGNATURE OF MEMBER	DATE OF SIGNATURE (mm/dd/ccyy) / /
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**INSTRUCTIONS FOR COMPLETING APPLICATION FOR
REFUND OF ACCUMULATED CONTRIBUTIONS TO MEMBER**

MEMBER INFORMATION. Verified and signed by the member as applicable.

MOVING WITHIN THREE (3) MONTHS? To be completed by member. **IF A MOVE IS ANTICIPATED WITHIN THE NEXT THREE (3) MONTHS, COMPLETE THIS SECTION PROVIDING THE EFFECTIVE DATE OF THE CHANGE OF ADDRESS.**

LUMP SUM DISTRIBUTION ELECTION. *Select only one option, A, B, or C.*
If A is selected, ERSRI will withhold 20% Federal taxes on the taxable portion of the refund paid directly to the member.
If option B or C is selected, the enclosed "Agreement of Trustee/Custodian" must be completed and the **ORIGINAL** form must be returned to ERSRI. **WE DO NOT ACCEPT COPIES OF ACCEPTANCE LETTERS.**

Be advised that all contributions received after the application date will be mailed directly to the member as a remainder check. Applicable taxes will be applied to amounts over \$10.

OPTIONAL ADDITIONAL FEDERAL TAX WITHHOLDING. Complete this section if A was selected under **LUMP SUM DISTRIBUTION ELECTION** and if additional Federal tax should be withheld in addition to the mandatory Federal tax withholding.

SIGNATURE. This section must be signed by the member.

FOR INFORMATION CONCERNING TAX CONSEQUENCES OF THIS DISTRIBUTION SEE IRS FORM 4972.

MAIL TO:
EMPLOYEES' RETIREMENT SYSTEM OF RHODE ISLAND
40 FOUNTAIN STREET, 1st Floor
PROVIDENCE, RI 02903-1854

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APPLICATION FOR REFUND OF ACCUMULATED CONTRIBUTIONS TO BENEFICIARY OF DECEASED MEMBER

Instructions: Please print or type in black ink. See reverse side for additional information.

RETIREMENT PLAN (CHECK ONE) State/Teachers Municipality State Police Judges

DECEASED MEMBER INFORMATION

SOCIAL SECURITY NUMBER		MEMBER'S BIRTH DATE (mm/dd/ccyy)	
NAME OF DECEASED MEMBER			

NAME AND ADDRESS OF BENEFICIARY OF DECEASED MEMBER

SOCIAL SECURITY NUMBER		DATE OF BIRTH (mm/dd/ccyy)		RELATION TO MEMBER	
NAME	FIRST	MI	LAST		
ADDRESS			HOME TELEPHONE NO	()	
ADDRESS			BUSINESS TELEPHONE NO	()	
CITY		STATE		ZIP	

LUMP SUM DISTRIBUTION ELECTION FOR SURVIVING SPOUSE OF DECEASED MEMBER (Check one)

A. <input type="checkbox"/>	100% Refund. The Employees' Retirement System is directed to make full payment to me, less applicable mandatory Federal tax withholding.
B. <input type="checkbox"/>	100% Direct Rollover/Transfer. The Employees' Retirement System is directed to mail the taxable portion of the distribution to my Trustee/Custodian(s) who has/have signed the Agreement of Trustee/Custodian. _____% will be sent to Trustee Custodian _____ _____% will be sent to Trustee/Custodian _____ The non-taxable distribution, if any, will be mailed to the above address.

If Option B was chosen, your Trustee/Custodian **must complete** the "Agreement of Trustee/Custodian" form.

FEDERAL TAX WITHHOLDING OPTIONS FOR BENEFICIARY OF DECEASED MEMBER OTHER THAN A SURVIVING SPOUSE (Check One)

A. <input type="checkbox"/>	I do not wish to have Federal tax deducted from my distribution. I realize that I may be liable for payment of Federal tax on the taxable portion of the distribution and that I may be subject to tax penalties under the estimated tax payment rules if my payment of estimated tax and withholding are not adequate.
B. <input type="checkbox"/>	The Employees' Retirement System is directed to make full payment to me, the beneficiary, less applicable Federal tax withholding as described in IRS Form 4972.

OPTIONAL ADDITIONAL FEDERAL TAX WITHHOLDING

In addition to the mandatory Federal tax withholding, I desire to have additional Federal tax withheld from the taxable distribution in the amount of \$ _____.

If the mandatory Federal tax is chosen to not be withheld, then additional Federal tax cannot be withheld.

SIGNATURE OF BENEFICIARY (This section must be signed by beneficiary.)

SIGNATURE OF BENEFICIARY	DATE OF SIGNATURE (mm/dd/ccyy) / /
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**INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR
REFUND OF ACCUMULATED CONTRIBUTIONS TO BENEFICIARY OF DECEASED
MEMBER**

NAME AND ADDRESS OF BENEFICIARY OF DECEASED MEMBER. To be verified and completed by beneficiary of deceased member.

MOVING WITHIN THREE (3) MONTHS? To be completed by the beneficiary. **IF A MOVE IS ANTICIPATED WITHIN THE NEXT THREE (3) MONTHS, COMPLETE THIS SECTION PROVIDING THE EFFECTIVE DATE OF THE CHANGE OF ADDRESS.**

LUMP SUM DISTRIBUTION ELECTION FOR SURVIVING SPOUSE OF DECEASED MEMBER. Select only one option, A or B. If A is selected, ERSRI will withhold 20% Federal taxes on the taxable portion of the refund paid directly to the spouse. If option B is selected, the enclosed "Agreement of Trustee/Custodian" must be completed and the **ORIGINAL** form must be returned to ERSRI. **WE DO NOT ACCEPT COPIES OF ACCEPTANCE LETTERS. A MAXIMUM OF TWO ROLLOVERS PER REFUND IS ALLOWED FOR DISTRIBUTION OF 100% OF TAXABLE CONTRIBUTIONS.**

LUMP SUM DISTRIBUTION ELECTION FOR BENEFICIARY OF DECEASED MEMBER. Option A is the only option available for beneficiaries. Beneficiaries have the option of having Federal taxes withheld or not withheld.

FEDERAL TAX WITHHOLDING OPTIONS FOR BENEFICIARY OF DECEASED MEMBER OTHER THAN A SURVIVING SPOUSE. This section to be completed by a beneficiary OTHER than a surviving spouse if additional taxes are to be withheld.

OPTIONAL ADDITIONAL FEDERAL TAX WITHHOLDING. Complete this section if additional Federal tax should be withheld in addition to the mandatory Federal tax withholding. If the mandatory Federal tax is chosen to not be withheld, then additional Federal tax cannot be withheld.
SIGNATURE OF BENEFICIARY. This section must be signed by the beneficiary.

FOR INFORMATION CONCERNING TAX CONSEQUENCES OF THIS DISTRIBUTION SEE IRS FORM 4972.

MAIL TO:
EMPLOYEES' RETIREMENT SYSTEM OF RHODE ISLAND
40 FOUNTAIN STREET, 1ST FLOOR
PROVIDENCE, RI 02903-1854

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 40 Fountain Street, 1st Floor
 Providence, RI 02903 - 1854
 Office (401) 222-2203, Fax (401) 222-2430

EMPLOYER CERTIFICATION/TERMINATION

Instructions: Please print or type in black ink. See reverse side for additional information.

MEMBER INFORMATION

SOCIAL SECURITY NUMBER					DATE OF BIRTH	
					mm/dd/ccyy	
NAME	FIRST		MI		LAST	
ADDRESS					HOME TELEPHONE NO	
ADDRESS					BUSINESS TELEPHONE NO	
ADDRESS						
CITY		STATE		ZIP	-	

EMPLOYMENT INFORMATION

NAME OF EMPLOYER		EMPLOYER IDENTIFICATION NO
DATE EMPLOYED	TITLE OF POSITION	POSITION ELECTED (Check One)
mm/dd/ccyy / /		<input type="checkbox"/> YES <input type="checkbox"/> NO

TERMINATION INFORMATION

DATE OF TERMINATION	LAST PAY PERIOD END DATE	DATE OF LAST WAGE/CONT. REPORT SUBMITTED
mm/dd/ccyy / /	mm/dd/ccyy / /	mm/dd/ccyy / /

REASON FOR SEPARATION FROM SERVICE (Check One)

RETIREMENT
 DEATH
 RESIGNED
 DISMISSED
 TRANSFERRED TO ANOTHER COVERED EMPLOYER
 TERMINATING COVERED EMPLOYMENT
 OTHER _____

UNREPORTED WAGES AND CONTRIBUTIONS

MONTH	WAGES	CONTRIBUTIONS	TYPE OF WAGES

FOR PUBLIC SCHOOL EMPLOYEES

CHECK ONE	IF CERTIFIED	IF NON-CERTIFIED
<input type="checkbox"/> CERTIFIED <input type="checkbox"/> NON-CERTIFIED	SUBSTITUTE DAILY RATE \$ _____	MINIMUM HOURLY WAGE RATE \$ _____
	CONTRACT DAILY RATE \$ _____	

EMPLOYER CERTIFICATION

I UNDERSTAND THAT ANY PERSON WHO MAKES A FALSE STATEMENT OR SHALL FALSIFY OR PERMIT TO BE FALSIFIED ANY RECORD OF THE RETIREMENT SYSTEM IN AN ATTEMPT TO DEFRAUD THE SYSTEM MAY BE SUBJECT TO CRIMINAL PROSECUTION, AND WITH THAT UNDERSTANDING, I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

AUTHORIZED SIGNATURE	DATE OF SIGNATURE
	mm/dd/ccyy / /
TITLE	TELEPHONE NO
	()

EMPLOYER CERTIFICATION OF TERMINATION

This form is to be completed by the employer when a Member terminates employment and for the purpose of receiving benefits from ERSRI.

MEMBER INFORMATION — To be completed by ERSRI or employer.

EMPLOYMENT INFORMATION — To be completed by employer.

TERMINATION INFORMATION — To be completed by employer.

UNREPORTED WAGES AND CONTRIBUTIONS — To be completed by employer. Types of wages include regular pay, overtime pay, contract payoff, and leave payments.

EMPLOYER CERTIFICATION — To be completed and signed by the authorized employer representative.

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AGREEMENT OF TRUSTEE/CUSTODIAN

Instructions: Please print or type in black ink. If the member is transferring contributions, the Member Information and Agreement of Trustee/Custodian sections must be completed. If spouse of deceased member is transferring contributions, Spouse of Deceased Member Information and Agreement of Trustee/Custodian sections must be completed. Return this original form. We will not accept your acceptance/transfer form.

MEMBER INFORMATION

FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER
ADDRESS			HOME PHONE NO
			BUSINESS PHONE NO
CITY	STATE	ZIP CODE	
SIGNATURE OF MEMBER		DATE (mm/dd/ccyy) / /	

SPOUSE OF DECEASED MEMBER INFORMATION

SOCIAL SECURITY NUMBER		DATE OF BIRTH (mm/dd/ccyy)	
FIRST NAME	MI	LAST NAME	
ADDRESS			HOME PHONE NO
			BUSINESS PHONE NO
CITY	STATE	ZIP CODE	
SIGNATURE OF SPOUSE OF DECEASED MEMBER		DATE (mm/dd/ccyy) / /	

AGREEMENT OF TRUSTEE/CUSTODIAN

In accordance with the authorization of the depositor, we agree to deposit the forthcoming rollover amount from the Employees' Retirement System of Rhode Island in the following account: (CHECK ONE)

Annuity IRA Other Qualified Plan

NAME OF TRUSTEE/CUSTODIAN	INDIVIDUAL'S ACCOUNT NUMBER	
ADDRESS		
ADDRESS		
CITY	STATE	ZIP
TRUSTEE/CUSTODIAN SIGNATURE (REQUIRED)		DATE (mm/dd/ccyy) / /
TAX IDENTIFICATION NUMBER (Not Required)		

**INSTRUCTIONS FOR COMPLETING
AGREEMENT OF TRUSTEE/CUSTODIAN**

Member Information.

To be completed and signed by the member as applicable.

Spouse of Deceased Member Information.

To be completed and signed by the spouse of the deceased member as applicable.

Agreement of Trustee/Custodian.

To be completed by an authorized employee of the applicable Trustee/Custodian.

NOTE TO TRUSTEE:

RETURN THIS ORIGINAL FORM. WE CAN NOT ACCEPT YOUR
ACCEPTANCE/TRANSFER FORM.

Mail To:

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