

EMPLOYEES' RETIREMENT SYSTEM OF RHODE ISLAND  
 50 Service Avenue  
 Warwick, RI 02886  
 Office (401) 462-7600 Fax (401) 462-7691  
 Email: [ersri@ersri.org](mailto:ersri@ersri.org) Web Site: [www.ersri.org](http://www.ersri.org)

## NON-PARTICIPATING MUNICIPALITY CREDIT REQUEST FORM

**Instructions: Please print or type in black ink. This form must first be authorized by the member and certified by current employer, forwarded to the former municipal employer for certification, then forwarded to the former retirement system for completion. The completed form must then be returned to the Employees' Retirement System of Rhode Island. Incomplete or inaccurate forms will not be processed.**

### MEMBER INFORMATION

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

### MEMBER AUTHORIZATION

**I, the undersigned, certify that the above information is true and correct. I understand that any member who knowingly makes a false statement regarding purchase credit shall not be entitled to a retirement allowance but only to a return of contributions.**

SIGNATURE OF MEMBER	DATE OF SIGNATURE (mm/dd/ccyy)
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### CURRENT EMPLOYER CERTIFICATION

CURRENT EMPLOYER AND POSITION	CURRENT CONTRACTUAL SALARY
<b>I hereby certify the above salary information to be true and correct based upon our official records.</b>	
SIGNATURE OF PERSONNEL OFFICIAL	DATE OF SIGNATURE (mm/dd/ccyy)

### FORMER EMPLOYER INFORMATION

MUNICIPALITY	TELEPHONE NUMBER	FAX NUMBER
ADDRESS		
ADDRESS		
CITY	STATE	ZIP

EMPLOYEE'S NAME	FIRST		MI		LAST	
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**FORMER EMPLOYER CERTIFICATION**

EMPLOYEE'S TITLE

Was service rendered on a substitute, temporary, casual or seasonal basis? Only time when the employee was regularly and permanently employed for a minimum of 20 hours or more per week qualifies for purchase.

YES

NO

Report service rendered in your municipality. List each Calendar year separately, and indicate whether service was rendered on a full-time or part-time basis. If service was part-time, please indicate percentage of full-time employment.

Period Of Employment		Number of Working Days (Max 260)	Full-Time (Hours per Week)	Part-Time (Hours per Week) (List % of Full-Time)
From (mm/dd/ccyy)	To(mm/dd/ccyy)			

Was there a former Retirement System?  YES  NO

If yes, after completing this section, please forward this form to the Retirement System in which the person was a member for completion.

I hereby certify the above information to be true and correct based upon our official records.

SIGNATURE	DATE OF SIGNATURE (mm/dd/ccyy)
PRINT NAME	TITLE

**FORMER RETIREMENT SYSTEM OR PENSION PLAN CERTIFICATION**

Is the member receiving or entitled to receive a benefit from your system or plan based on this service?

YES

NO

If this member becomes eligible to receive a retirement benefit from your system, which includes the service certified for purchase in the Employees' Retirement System of Rhode Island, please inform this office immediately.

SIGNATURE	DATE OF SIGNATURE (mm/dd/ccyy)
PRINT NAME	TITLE

NAME OF RETIREMENT SYSTEM