



MainePERS
PUBLIC EMPLOYEES RETIREMENT SYSTEM

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APPLICATION FOR SERVICE RETIREMENT BENEFITS

Please type or print all information and keep a copy for your records.

MEMBER DATA

Social Security Number: Maine Resident: ☐ Yes ☐ No (For state income tax purposes)

Member's Name:
(First) (MI) (Last) (Suffix)

Mailing Address:
(Street/PO Box) (City/Town) (State) (ZIP)

Marital Status: ☐ Married ☐ Single Home Telephone Number: Home E-mail Address:

Termination Date: Effective Date of Retirement*: **01** *The first day of the month after you terminate employment or reach normal retirement age.
(month) (day) (year) (month) (day) (year)

OPTION ELECTION: I elect the following option:

- | | |
|---|---|
| <input type="checkbox"/> Full Benefits/Special Plan | <input type="checkbox"/> Option 4 - % to beneficiary at your death: _____ % |
| <input type="checkbox"/> Option 1 | <input type="checkbox"/> Option 5 - % to beneficiary at your death: _____ % |
| <input type="checkbox"/> Option 2 | <input type="checkbox"/> Option 6 |
| <input type="checkbox"/> Option 3 | <input type="checkbox"/> Option 7 |
| | <input type="checkbox"/> Option 8 - % to beneficiary at your death: _____ % |

BENEFICIARY DESIGNATION

- You can NOT name a beneficiary if you elect FULL BENEFITS.
- Before you name someone not on your estimate, contact us to learn how that changes your monthly benefit amount.

Gender: ☐ Male ☐ Female ☐ X

Beneficiary's Name:
(First) (MI) (Last) (Suffix)

Mailing Address:
(Street/PO Box) (City/Town) (State) (ZIP)

Home Telephone Number: Home E-mail Address:

Social Security Number: Relationship:

SIGNATURE: By signing this form I state that:

- I have read and understand all the information on this form.
- I chose how I want to receive my service retirement benefits and know my options from the information provided with my estimate.
- I know I cannot cancel my retirement or change my option choice after the first payment is issued.
- I know that I give up my rights to earn more service credit or higher earnable compensation if I return to work after retirement.

Signature of Applicant _____ (Date) _____

NOTARIAL CERTIFICATE: This form must be acknowledged by a Notary Public or other Notarial Officer.

State of _____, County of _____

Acknowledged before me by _____ on this _____ day of _____, 20____
(Member's Name)

(Signature of Notary)

Stamp or Printed Name: _____

Title of Office: _____
(i.e., Notary Public, Attorney, etc.)

Notary Public Commission Expiration Date: _____