Judicial Plan
Application for Retirement

Member Information:

Name:_____ Social Security#:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone #:_____ Date of Birth:_____

Email:_____

❒ *Check box if new address*

Final Date of Employment:_____ Retirement Date:_____

Jurisdiction:_____

Survivor Information:

Name of Survivor:_____

Address:_____

City:_____ State:_____ Zip:_____

Social Security #:_____ Date of Birth:_____

Relationship:_____

BOTH SIGNATURES MUST BE SIGNED BEFORE A NOTARY **(see page 2)**

DESCRIPTION OF PLAN

The benefit under the Judicial Retirement Plan is a joint survivor benefit. Upon your death, your survivor will receive one-half (1/2) of the monthly amount you had been receiving for the remainder of his or her life.

Member's Signature X_____ Date_____

Spouse's Signature X_____ Date_____

AFFIDAVIT OF MARITAL STATUS
(Must be completed if you are not married)

I, _____, hereby declare that as of the date below, I am **not** married, and I am not required to provide a spouse=s signature above.

X_____
Member's Signature Date

WRS Office Use Only

Entered: _____

Verified: _____

BOTH Signatures on Page 1 Must be Notarized

NOTARY ACKNOWLEDGMENT

State of _____
County of _____ } ss.

On *(date)*_____ , before me, *(notary's name)* _____ ,
personally appeared *(member's name)* _____ and
(spouse's name) _____ ,

❒ proved to me on the basis of satisfactory evidence **OR** ❒ personally known to me
to be the person(s) whose name(s) is/are subscribed to the attached document: *(please check box below)*

❒ RETIREMENT APPLICATION
❒ WITHDRAWAL OF MEMBER CONTRIBUTIONS
❒ CHANGE OF NAME/ADDRESS/BENEFICIARY FORM

dated _____ ,
and acknowledged to me that he/she/they executed the same.

WITNESS my hand and official seal. *Notary Seal*

X_____ _____
Signature of Notary Public *My Commission Expires*

NOTARY ACKNOWLEDGMENT

To be completed only if spouse's signature is not already notarized above.

State of _____
County of _____ } ss.

On *(date)*_____ , before me, *(notary's name)* _____ ,
personally appeared *(spouse's name)* _____ ,

❒ proved to me on the basis of satisfactory evidence **OR** ❒ personally known to me
to be the person whose name is subscribed to the attached document: *(please check box below)*

❒ RETIREMENT APPLICATION
❒ WITHDRAWAL OF MEMBER CONTRIBUTIONS
❒ CHANGE OF NAME/ADDRESS/BENEFICIARY FORM

dated _____ ,
and acknowledged to me that he/she executed the same.

WITNESS my hand and official seal.

X_____
Signature of Notary Public

_____
My Commission Expires *Notary Seal*

WRS Office Use Only

Entered: _____
Verified: _____

BIRTH CERTIFICATION

If you do not want to send copies of your birth records, administrators and supervisors are authorized to examine the documents and certify by signing below. *Documents from* **Group A** *submitted for examination must show the date of birth of the member and survivor (if applicable). Documents from* **Group B** *must show the date of birth or age and date the document was executed.*

To be Completed by Administrator or Supervisor

Member's Name: _____

Social Security #: _____ Employed by: _____

Member's Date of Birth: _____

Title of Document Presented	Date Document was Executed	Date of Birth or Age Shown on Document	Is Document Original, Certified Copy, Photocopy?

Survivor's Name: _____

(For Options 2, 2P, 3, 3P) **Survivor's** Date of Birth: _____

Title of Document Presented	Date Document was Executed	Date of Birth or Age Shown on Document	Is Document Original, Certified Copy, Photocopy?

I hereby certify that the documents shown above were presented to me by the employee named, and that said documents were, in my opinion, valid instruments, and the birth dates recorded hereon are as they appeared on said documents.

_____ X _____ _____

Date Administrator's Signature Title

If a birth certificate is not available, please submit records of your birth using the following documents as proof of age. Do not send originals or certified copies; photocopies are requested.

Group A (One Document Sufficient): or **Group B** (Three Documents Required):

Delayed Birth Certificate
Naturalization Papers
Baptismal Record
Church Records
Family Bible Record
Census Records
Newspaper Record of Birth
Passport

Insurance Policies
Hospital Record
Physician's Record
School Records
Armed Forces Record
Birth Certificate of Child
Licenses (Driving, Hunting, Etc)
Voting Registration Record
Marriage Records
Records of Social/Fraternal Org.
Employment Records

WRS Office Use Only

Entered: _____

Verified: _____

Wyoming Retirement System
AUTOMATIC PAYROLL DEPOSIT*
(Please Print or Type)

Member's Name: _____ SSN: _____

Financial Institution Information:

Financial Institution's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone#: _____

9-Digit Bank Routing Number: __ __ __ __ __ __ __ __ __

CHECKING Account Number: _____

OR **SAVINGS** Account Number: _____

Deposit: _____ 100% OR $_____ each payday

Complete section below if benefit is split between two accounts. Specify the amount to be credited to each account.

Financial Institution Information:

Financial Institution's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone#: _____

9-Digit Bank Routing Number: __ __ __ __ __ __ __ __ __

CHECKING Account Number: _____

OR **SAVINGS** Account Number: _____

Deposit: _____ 100% OR $_____ each payday

Member's Signature: X_____ **Date:** _____

Please Attach Voided Check

(if available)

WRS Office Use Only

Entered: _____

Verified: _____

*Required by WRS; may be changed anytime by *written* instruction to the payroll section of WRS.

WRS-A9 Tax Form
(Revised 05/11)

Wyoming Retirement System
FEDERAL INCOME TAX WITHHOLDING

Name:_____ Social Security #:_____

Address:_____

City:_____ State:_____ Zip:_____

☐ *Check box if new address*

➤ ☐ I am retiring soon. My INITIAL withholding is as follows; **OR**

➤ ☐ I am already retired. Please CHANGE my current withholding as follows:

Please check the box(es) that apply to your tax status

1. ☐ I want to have WRS calculate my withholding based on current IRS tax tables. I realize that even though I have chosen this option, my monthly benefit may not be subject to taxation.

   → Filing Status ***(please circle one)*** .....Married or Single
   → Exemptions Claimed ***(please circle one)*** ...0 1 2 3 4 5 6 7 8 9 10

2. ☐ Withhold $_____ per month IN ADDITION to the amount I am currently having withheld.

3. ☐ Withhold $ _____ of my taxable benefit each month (TOTAL amount)

4. ☐ Withhold _____% (percent) of my taxable benefit each month.

5. ☐ I do NOT want federal withholding tax deducted from my retirement benefit. I understand I am liable for the payment of federal income tax on the taxable portion of my benefit. If my payments of estimated tax are not adequate, I understand I may be subjected to tax penalties under the estimated tax payment rules.

Signature X_____ **Date** _____

☐ Each January you will receive a 1099-R form (Distributions from Retirement Plans) for federal income tax purposes.

☐ You may update your tax information anytime by ***written*** instruction to the Wyoming Retirement System. If you are making a change, please return this form by the 20th of any month.

WRS Office Use Only

Entered: _____

Verified: _____

Wyoming Retirement System ◆ 6101 Yellowstone Road, Suite 500 ◆ Cheyenne, Wyoming 82002
Phone: (307) 777-7691 ◆ Fax: (307) 777-7157 ◆ http://retirement.state.wy.us

PRUDENTIAL LIFE INSURANCE

IF YOU ARE NOT CURRENTLY ENROLLED, DO NOT COMPLETE THIS FORM

If you do not know if you are enrolled, please contact your payroll clerk or check your pay stub for a $9.00, $12.00, or $16.00 Prudential deduction. You can also contact HealthSmart, the company who administers the Prudential Life Insurance plan at (800) 525-8056.

Name: _____ SS#: _____

Address: _____

City: _____ State:_____ Zip: _____

❒ *Check box if new address*

If you are **currently** participating in the Prudential Life Insurance program and want to continue your Prudential coverage in retirement, please complete the following information.

❒ YES, I want to continue having the Prudential Life Insurance premium deducted from my retirement check ***(Please take this to your Employer to complete section below)***

❒ NO, I do not want to continue the Prudential Life Insurance

If YES, please provide your beneficiary information below:

Beneficiary's Name: _____

Beneficiary's Address: _____

_____

Beneficiary's Social Security Number: _____

Relationship to Member: _____

Signature: X_____ **Date:**_____

TO BE COMPLETED BY EMPLOYER:

Employer ID#: _____ Employer Name: _____

Employee's last working day _____

Did Employee have Prudential Life Insurance offered through WRS? ❒ Yes ❒ No

If yes, amount of premium: ❒ $16.00 ❒ $12.00 ❒ $9.00

Final premium will be paid on _____ in the amount of $_____
(date)

Employer's Signature ▶ _____ Date:_____

- *If you are under 60 years of age, become totally disabled (as determined by Prudential), and have been disabled for at least nine (9) months, your Schedule of Benefits for Group Decreasing Term Life Insurance may be continued without further contributions as long as you annually furnish proof of your continued disability satisfactory to Prudential. For information about applying for a Waiver of Premium, call HealthSmart Benefit Solutions, Inc. at 800-525-8056. The Waiver of Premium does not apply to dependent spouse, domestic partner, or child coverage.*

WRS Office Use Only

Entered: _____

Verified: _____