# APPLICATION INSTRUCTIONS AND CHECKLIST - Warden, Patrol, DCI Plan

Please verify the following information before submitting application packet. **Once you have turned in your application, ANY changes to the actual application page will require a new application to be completed.**

**Application (required)**

- ☐ Name, address, social security number, date of birth, telephone number, and employment information
- ☐ Last Working Day is the day your employment with a covered agency ends
- ☐ Effective Retirement Date. In *most* cases, this is the day after your actual last working day (or the day after your last day of used, EARNED sick or annual leave). If your account has been inactive, and/or you are not sure what retirement date to list, please contact our office.
- ☐ **The beneficiary section MUST be completed unless you choose option 5**. If you retire under Option 1, your spouse must be your beneficiary. Please provide your beneficiary's name and address (if different than your address), social security number and date of birth. If you have more than one beneficiary, complete the "*Additional/Contingent Beneficiaries"* form. **MEMBER must sign and date form.**
- ☐ Signature by option you are selecting. If you are married, your spouse must also sign. ***APPLICATION MUST BE SIGNED IN FRONT OF A NOTARY.*** An Acknowledgment Form is attached for the notary to complete. If signatures are not notarized properly, your retirement may be delayed. **Option 2 may not be available if you have a non-spouse beneficiary. Please contact WRS for further information.**
- ☐ If you are unmarried, the Affidavit of Marital Status must be completed and signed

**Acknowledgment Form (required)**

- ☐ Notary must notarize both signatures on application

**Birth Certification** (if no birth certificate, see list for other acceptable documents) ➤➤➤

- ☐ Photocopy of your Birth Certificate
- ☐ Photocopy of your Beneficiary's Birth Certificate if you are retiring under 2

**Other Acceptable Documents for Birth Certification** (photocopies please)

**Group A** (One Document Sufficient):
Delayed Birth Certificate
Naturalization Papers
Baptismal Record
Church Records
Family Bible Record
Census Records
Newspaper Record of Birth
Passport

**OR**

**Group B** (Three Documents Required):
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

**Automatic Payroll Deposit Form**

- ☐ Name and social security number
- ☐ Financial Institution's name, address, telephone number
- ☐ Routing number and account number
- ☐ Signature and date
- ☐ Attach a voided check (if available)

**Federal Income Tax Withholding Request Form**

- ☐ Name, address, social security number
- ☐ A tax option is selected
- ☐ If Box 1 is checked,
  - ☐ Filing status
  - ☐ Total exemptions claimed
- ☐ Signature and date

**Prudential Life Insurance Form (optional)** and only if enrolled in plan prior to retirement

- ☐ Name, address, social security number
- ☐ Beneficiary(ies) name, address, social security number, relationship
- ☐ If additional space is needed, please complete Additional/Contingent Beneficiary Form WRS-A7
- ☐ Signature and date
- ☐ ***If continuing Prudential, your employer must complete Employer section***

**Other (if applicable)**

- ☐ Check with your Health Insurance Administrator concerning insurance coverage once you retire
- ☐ Check with a representative of your 457 Deferred Compensation Plan or your 403(b) Tax Sheltered Annuity Plan for retirement options

# BENEFIT OPTIONS AVAILABLE
# PATROL/WARDEN/DCI PLAN

**OPTION 1** A monthly benefit payable as long as YOU OR YOUR SPOUSE LIVE. Upon your death, your spouse will receive one-half (1/2) of the benefit you had been receiving. In addition, we will pay an amount equal to 5% of your final average salary as a death benefit for each unmarried child under the age of eighteen (18) years. The total death benefit paid to your surviving spouse and children cannot exceed 60% of your final actual salary.

**OPTION 2** A monthly benefit payable as long as YOU OR YOUR BENEFICIARY LIVE. Upon your death, your beneficiary would receive the same monthly benefit you had been receiving. After the death of both you and your beneficiary, if the total benefit paid is less than the total of your contributions and interest at the time you retired, your contingent beneficiary would receive a lump-sum refund. ***This option may not be available if you have a NON-SPOUSE beneficiary. Please contact WRS for further information.***

**OPTION 3** Not available under this plan.

**OPTION 4** A monthly benefit payable during YOUR LIFETIME. If your death occurs before you have received the benefit for ten years, your beneficiary will receive the same monthly benefit for the BALANCE OF THE TEN-YEAR PERIOD, after which the benefit ceases. A contingent beneficiary may be named in the event your death and the death of your designated beneficiary occur before the ten-year anniversary date.

**OPTION 5** A monthly benefit payable during YOUR LIFETIME ONLY. This is the highest benefit, however, there are no provisions to pay a beneficiary after your death.

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Option 2 will be less than Option 1 because the benefit is based on two life expectancies. Option 4 will be less than Option 1 because of the guarantee of a ten-year certain benefit. If you wish to have an estimate for Option 2, you will need to provide our office with your beneficiary's birth date. Option 5 is only slightly higher than Option 1 since you forfeit all beneficiary rights.

It is your responsibility to notify this office prior to the date you wish to begin receiving your monthly benefit. You must choose an option when you complete your application for retirement. **ONLY ONE OPTION MAY BE SELECTED. ONCE AN OPTION IS CHOSEN AND YOU RECEIVE YOUR FIRST MONTHLY BENEFIT, YOU CANNOT CHANGE THE OPTION.**

All retirement checks are issued the last working day of each month. Your first benefit check will not be processed until our office has received the final contribution from your employer. A one-time payment retroactive to your retirement date is made with the first check, if necessary.

**If, after retirement, you return to work for an agency covered by the State Highway Patrol, Game and Fish Warden, and Criminal Investigator Retirement Act, you must notify our office.**

**WYOMING RETIREMENT SYSTEM**
**6101 YELLOWSTONE ROAD, SUITE 500**
**CHEYENNE, WYOMING 82002**
**(307)777-7691**

# PATROL/WARDEN/DCI PLAN

## Application for Retirement

**_WRS Office Use Only_**

Acct#:____________________

Agency:____________________

Last Completed by:____________

Retirement Date:_____________

Checked by:________________

Entered: ____________________

Verified: ____________________

1 Member's Name:________________________________ SS #:____________________

Address:______________________________________________________________

City:________________________________________ State:_________ Zip:____________

Phone #:______________________________ Date of Birth:______________________

Email: ______________________________________________________________

❒ *Check box if new address*

2 Last Working Day:__________________ Effective Retirement Date:__________________

3 Employed by:____________________________________ Position:__________________

4 Beneficiary Information: *Please note, under Option 1 only, your spouse must be your beneficiary*

Beneficiary's Name:______________________________SS #:____________________

Address:______________________________________________________________

City:________________________________________ State:_________ Zip:____________

Relationship:______________________________ Date of Birth:______________________

***Select Retirement Option Below***

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

**OPTION 1** **A Joint and One-Half Survivor benefit payable as long as YOU OR YOUR SPOUSE live.** The total benefit paid to your surviving spouse and children under the age of 18 cannot exceed 60% of your final actual salary.

Member's Signature__________________________________________ Date______________________

Spouse's Signature__________________________________________ Date______________________

**List any dependent children under the age of 18 on a separate sheet of paper and attach to your application.**

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**OPTION 2** **A Full Joint and Survivor benefit payable as long as YOU OR YOUR BENEFICIARY live.**

Member's Signature__________________________________________ Date______________________

Spouse's Signature__________________________________________ Date______________________

**Contingent Beneficiary Designation** *(List contingent beneficiary(ies) on a separate, signed attachment)*

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**OPTION 4** **A monthly benefit during your lifetime, with a 10-year certain payout.**

Member's Signature__________________________________________ Date______________________

If the member dies prior to the 10th year of retirement, the monthly benefit will continue to be paid to the beneficiary up to that ten-year anniversary date.

Spouse's Signature__________________________________________ Date______________________

**Contingent Beneficiary Designation** *(List contingent beneficiary(ies) on a separate, signed attachment)*

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**OPTION 5** **A monthly benefit during your lifetime only, with no beneficiary provisions.** If your death occurs before all of your contributions and interest have been paid to you, the remaining funds revert to the retirement system.

Member's Signature__________________________________________ Date______________________

I understand that I am not entitled to a monthly benefit or lump-sum payment upon the death of the member.

Spouse's Signature__________________________________________ Date______________________

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## 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 under the option I have chosen for retirement.

Member's Signature__________________________________________ Date______________________

**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

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

**Group B** (Three Documents Required):

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 ◆ 6101 Yellowstone Road, Suite 500 ◆ Cheyenne, Wyoming 82002
Phone: (307) 777-7691 ◆ Fax: (307) 777-5995 ◆ http://retirement.state.wy.us

**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*

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➤ ☐ 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: ____________________

# 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: ______________