ARKANSAS PUBLIC EMPLOYEES RETIREMENT SYSTEM (APERS)

MEMBERSHIP DATA FORM (MDF)

Part 1 – To Be Completed By Employee

(If you are a retired member of APERS receiving a monthly annuity benefit, you are not eligible to participate in APERS.)

Please list below the exact name and Social Security Number under which your individual account will be kept by the System. All future transactions with APERS should be made under this name except in case of legal change of name. Use your full legal name. **Do not use nicknames**. If your legal name changes, complete a Change of Name Form and forward it to us.

____ ____________

Last Name **First Name** **Middle Initial** **Social Security No.**

Employed By: ❑State ❑County ❑Municipal ❑Non-State

1. Date of Birth: ______________________________ Sex ❑Male ❑Female
   Month Day Year

2. Home Address: ____
   Street Number or Route Number City County State Zip Code

3. If married, give full name of spouse: ______________________ Spouse's Date of Birth: __________

4. Other than Social Security, are you retired or have you ever been or will be a member of any other State of Arkansas authorized retirement system other than APERS? If so, list specific dates.

Arkansas Teacher Retirement System	❑Yes	❑No	Dates ____________
Arkansas Highway Retirement System	❑Yes	❑No	Dates ____________
LOPFI	❑Yes	❑No	Dates ____________
Arkansas State Police Retirement System	❑Yes	❑No	Dates ____________
Arkansas Judicial Retirement System	❑Yes	❑No	Dates ____________
Arkansas District Judges Retirement System	❑Yes	❑No	Dates ____________
Alternate Retirement plans (i.e. TIAA, Valic)	❑Yes	❑No	Dates ____________

If Yes, list employer ______________________________

5. Have you ever been a member of APERS? ❑Yes ❑No
   If YES, give the date(s) and agency('s) worked for.

   Dates ______________ Agency ______________
   Dates ______________ Agency ______________
   Dates ______________ Agency ______________

Signature of Member: ______________________________ Date: ____________

Part 2 – To Be Completed By Agency Representative

1. Name of Agency: ______________________________

2. Dept. Number (As shown on earnings report transmitted to this office:) ____ ____ ____ ____ ____

3. Address of Agency: ______________________________
   Street Number or Route Number City County State Zip Code

4. Date of Above Employee's First Day of Work: ______________ ❑Contributory. ❑Non-Contributory
   (If the employee was employed in a position covered by APERS and terminated and returned to covered employment within 6 months of said termination, they are eligible to return as a non-contributory member).

5. Job Title: ______________________________

Signature and Title of Agency Rep.: ______________________________ Date: ____________

It is understood that, although designated as employee contributions, the contributions are being paid by the employer in lieu of contributions by the employee, and that the employee must NOT be given the option of choosing to receive the contributed amounts directly instead of having them paid by the employer to APERS.

NOTE: We cannot enroll the above employee unless all the information is answered completely and a copy of their social security card (for identification purposes) is enclosed along with a Designation of Beneficiary Form. **REV. 9/2005**

ARKANSAS PUBLIC EMPLOYEES RETIREMENT SYSTEM
124 W. Capitol Ave, Suite 400
Little Rock, AR 72201

Return to APERS Covered Employment

(In Compliance with ACA 24-4-1101(c))

FOR COMPLETION BY MEMBER

I, ______________________________________, terminated as a non-contributory member from a
(Printed Member Name)

position covered APERS employer and have returned to a position covered by APERS within six (6) months, and elect to be covered as a(an):

____ Non-Contributory Member

____ Contributory Member

I understand that as a member of the contributory plan, 5% of my pretax earnings will be submitted to APERS on my behalf. I also understand that there are many differences between the contributory and the non-contributory provisions of the Retirement System, and I realize that this election is irrevocable.

____ _________________________

Member Signature Date

____

Social Security Number

____

Address

FOR COMPLETION BY EMPLOYER

I, ________________________________, representing ______________________________________/
(Printed Employer Representative Name) **(Printed Employer Name)**
______________________________ indicate by my signature below that I have been advised that
(APERS Employer Number)
the above referenced employee has made an irrevocable election in compliance with ACA 24-4-1101(c) regarding their APERS membership.

I further understand that (i) this election by a member must be made immediately upon hire; (ii) although designated as employee contributions, the contributions are being paid by the employer in lieu of contributions by the employee; and (iii) the employee must NOT be given the option of choosing to receive the contributed amounts directly instead of having them paid by the employer to APERS.

____ __________________

Employer Representative Signature Date

(NOTE: This form is to be completed (along with the Membership Data Form) if the employee is returning to an APERS covered position within six (6) months of their prior coverage).