

# Sixty Day Enrollment Form



San Mateo County Employees' Retirement Association  
 100 Marine Parkway, Suite 125, Redwood Shores, CA 94065  
 Phone: (650) 599-1234 Toll Free: (800) 339-0761 **PONY: RET141**  
 Web: [www.SamCERA.org](http://www.SamCERA.org) Email: [SamCERA@SamCERA.org](mailto:SamCERA@SamCERA.org)

I acknowledge that I am enrolled in *SamCERA's* Contributory Plan 4.

## PART 1 - ENROLLMENT INFORMATION

|   |   |   |
|---|---|---|
| <b>SS Number or Employee ID:</b>  | <b>Last Name:</b>   | <b>First and Middle Name:</b>   |
| <b>Sex:</b> Male <input type="checkbox"/> Female <input type="checkbox"/>   | <b>Date of Birth:</b>   | <b>Start of Current County Employment:</b>  |
| <b>Department:</b>  | <b>Work Telephone:</b>  | <b>Pony Address:</b>  |
| <b>Status:</b><br><input type="checkbox"/> I am married<br><input type="checkbox"/> I am not married<br><input type="checkbox"/> I have a domestic partner registered with the California Secretary of State. (Please attach a copy of your certificate.) | <b>If you have worked for the County before, enter the dates:</b>   | <b>If your name has changed since your prior employment with the County, enter your former name(s):</b> |
| <b>If you have come to SamCERA from another public agency in the State of California within 6 months, enter the dates you last worked for another public agency:</b><br>Enter the name of your former public agency:                                      | <b>If you came from another California public agency within 6 months, would you like to establish Reciprocity, if you are eligible?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |

## PART 2 - DESIGNATION OF BENEFICIARY

**This form must be completed and on file in SamCERA's Office to qualify a beneficiary for your death benefits.**

**You must complete and file a new Designation of Beneficiary form if you wish to change your beneficiary.**

I hereby designate the following person(s) as my Beneficiary(ies) for applicable *SamCERA* death benefits: Please specify if primary or contingent and include the distribution percentage for each beneficiary and insure that primary and contingent totals each add up to 100% for each section. Notice: SamCERA will not distribute benefits to person(s)/entity(ies) without Social Security Number or Tax Payer ID Numbers. See **First Things First: A Guide to SamCERA's New County General or Safety Members** for information about primary and contingent beneficiary.

Primary  Contingent  Alternate Contingent

|                      |   |              |
|----------------------|---|--------------|
| Beneficiary Name     | Relationship  | % of Benefit |
| Date of Birth        | Social Security Number/Taxpayer Identification Number |              |
| Home/Mailing Address | Daytime Phone Number<br>( )                           |              |
| City                 | State   | Zip Code     |

Primary  Contingent  Alternate Contingent

|                      |   |              |
|----------------------|---|--------------|
| Beneficiary Name     | Relationship  | % of Benefit |
| Date of Birth        | Social Security Number/Taxpayer Identification Number |              |
| Home/Mailing Address | Daytime Phone Number<br>( )                           |              |
| City                 | State   | Zip Code     |

Primary     Contingent     Alternate Contingent

|                      |   |              |
|----------------------|---|--------------|
| Beneficiary Name     | Relationship  | % of Benefit |
| Date of Birth        | Social Security Number/Taxpayer Identification Number |              |
| Home/Mailing Address | Daytime Phone Number<br>(     )                       |              |
| City                 | State   | Zip Code     |

Primary     Contingent     Alternate Contingent

|                      |   |              |
|----------------------|---|--------------|
| Beneficiary Name     | Relationship  | % of Benefit |
| Date of Birth        | Social Security Number/Taxpayer Identification Number |              |
| Home/Mailing Address | Daytime Phone Number<br>(     )                       |              |
| City                 | State   | Zip Code     |

Primary     Contingent     Alternate Contingent

|                      |   |              |
|----------------------|---|--------------|
| Beneficiary Name     | Relationship  | % of Benefit |
| Date of Birth        | Social Security Number/Taxpayer Identification Number |              |
| Home/Mailing Address | Daytime Phone Number<br>(     )                       |              |
| City                 | State   | Zip Code     |

### TRUST OR CHARITY

Primary     Contingent     Alternate Contingent    (Lump sum payment only)

If you name more than one beneficiary please include the percentage to be distributed to each beneficiary and be sure the total adds up to 100%

|  |   |                   |
|--|---|-------------------|
| <input type="checkbox"/> TRUST <input type="checkbox"/> CHARITY<br>(Please attach a copy of your Trust documents.) | Name of Trust Administrator or Charity Contact: | % of Benefit:     |
| For Charity, Federal Tax Identification Number:  | Address of Trust Administrator or Charity:      | Telephone Number: |

Primary     Contingent

|  |   |                   |
|--|---|-------------------|
| <input type="checkbox"/> TRUST <input type="checkbox"/> CHARITY<br>(Please attach a copy of your Trust documents.) | Name of Trust Administrator or Charity Contact: | % of Benefit:     |
| For Charity, Federal Tax Identification Number:  | Address of Trust Administrator or Charity:      | Telephone Number: |

### PART 3 - SWORN STATEMENT

I declare under penalty of perjury that the information on this form is true and correct.

|   |   |       |
|---|---|-------|
| Signature of Member:                              |   | Date: |
| Signature of Spouse/Domestic Partner (Mandatory): | Date of Marriage or CA Domestic Partnership Registration: | Date: |