

**SAFETY MEMBER ENROLLMENT FORM**



**THIS FORM MUST BE RETURNED**

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)

**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> <input type="checkbox"/> I am married <input type="checkbox"/> I am not married <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: Enter the name of your former public agency:</b>	<b>If you came from another California public agency within 6 months, would you like to establish Reciprocity, if you are eligible?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

**PART 2 – DECLARATION**

I acknowledge that I have been automatically enrolled in Plan 4 and will have contributions and cost share deductions taken from my salary each pay period. Upon retirement under Plan 4, I will be eligible for an annual cost-of-living increase.

**PART 3 - DESIGNATION OF BENEFICIARIES**

*This form must be completed and on file in SamCERA's Office to qualify a beneficiary(ies) 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 ensure that primary and contingent totals each add up to 100%. 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 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 (    )	
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 (    )	
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 (      )	
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 (      )	
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 (      )	
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"/> <b>TRUST</b> <input type="checkbox"/> <b>CHARITY</b> (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"/> <b>TRUST</b> <input type="checkbox"/> <b>CHARITY</b> (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 4 - SWORN STATEMENT

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

<b>Signature of Member:</b>		Date:
<b>Signature of Spouse/Domestic Partner (Mandatory):</b>	Date of Marriage or CA Domestic Partnership Registration:	Date: