CECIL COUNTY PENSION PLAN FOR PUBLIC SAFETY EMPLOYEES
BOARD OF TRUSTEES
200 Chesapeake Boulevard, Suite 2800
Elkton, MD 21921
(410) 996-5250, FAX: 1-888-522-7158

Application for Membership

PRINT IN INK OR TYPE

Employee Information

Name: _____ Date of Birth: _____

Social Security Number: _____ Sex (M or F): _____

Home Address (Street, City, State, Zip Code):

_____

_____

1. Have you ever been a member of the Cecil County Public Safety Pension Plan? ☐ Yes ☐ No
2. Are you presently receiving a retirement allowance from any Pension System? ☐ Yes ☐ No
3. When did you begin your present continuous service with Cecil County Government? _____
4. Do you have any physical limitations or disability? If yes, describe: _____
5. Are you receiving or have you ever received any type of disability payments? ☐ Yes ☐ No
6. If Yes, describe the nature and extent of the disability and from whom you are receiving or have received payment: _____

TO THE BOARD OF TRUSTEES:
I certify that all statements made on this application are correct. I certify that I have received a copy of the Pension Plan Document. I authorized any required deductions from my salary in accordance with the prescribed rate of contribution and these amounts shall be recorded to my credit by the Cecil County Public Safety Pension Plan to the annuity savings account.

Signature: _____ Date: _____

Retirement Coordinator Completes This Section

A. When did the applicant begin present continuous service? _____ MONTH/DAY/YEAR

B. What is the applicant's complete job classification or job title? _____

C. What is the applicant's annual salary? _____

D. What are the applicant's standard hours? _____

E. Number of pay periods reported per year? _____

FOR DEPARTMENT OF HUMAN RESOURCES ONLY

_____ **Signature**

_____ **Plan Entrance Date**

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Designation of Beneficiary

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Use this form to designate the person (or persons) who will receive a benefit under the Public Safety Pension Plan in the event of your death. After you complete this form, forward directly to the Benefits Manager in the Department of Human Resources. Please refer to Article 3, Section 3.5 of the Pension Plan document for a description of the Plan's Death Benefits and information regarding the designation of beneficiaries.

Participant Information

Name | **Social Security Number** | **Date of Birth**

Address (Street, City, State, Zip Code)

Primary Beneficiary(ies) – All money shall be paid in equal shares to the primary beneficiary(ies) who are living at the time of my death.

Primary Beneficiary Name | **Social Security Number** | **Date of Birth**

Address (Street, City, State, Zip Code)

Primary Beneficiary Name | **Social Security Number** | **Date of Birth**

Address (Street, City, State, Zip Code)

Contingent Beneficiary(ies) – If all primary beneficiaries die before me, all money shall be paid in equal shares to the following person(s) who are living at the time of my death.

Contingent Beneficiary Name | **Social Security Number** | **Date of Birth**

Address (Street, City, State, Zip Code)

Contingent Beneficiary Name | **Social Security Number** | **Date of Birth**

Address (Street, City, State, Zip Code)

I authorize the Public Safety Pension Plan to pay the death benefit to my designated beneficiary or beneficiaries. I agree on behalf of my estate, heirs, and assigns that the payment made by the Plan will release the Plan from any further obligation regarding this benefit. I direct the Plan to pay the death benefit to my estate if I have not designated any beneficiary or if all of the primary and contingent beneficiaries I have named die before me. I understand that I may change beneficiaries at any time by filing a new Designation of Beneficiary form. Any new Designation of Beneficiary form I file will replace this form. I understand certain payments due to a minor shall be made only to the legal guardian of that minor.

Employee's Signature Date

Human Resources Representative Date

Rev: 7/2010 - AMG