



Employee Enrollment Request

124 West Capitol Avenue Suite 400 • Little Rock AR 72201-3700
 Phone: (800)682-7377 • Fax: (501)682-7843 • Website: www.apers.org

I. Employee Information		
Social Security Number	Name (Last, First, Middle Initial)	
Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
Mailing Address		City, State, Zip Code
Email Address		Daytime Telephone Number

II. Reciprocal System Information		
Indicate All Reciprocal Systems or Plans in Which You Have Credited Service		
<input type="checkbox"/> None <input type="checkbox"/> ATRS <input type="checkbox"/> ASHERS <input type="checkbox"/> ASPRS <input type="checkbox"/> AJRS <input type="checkbox"/> LOPFI <input type="checkbox"/> Alternate Plan (ex: TIAA-CREF, VALIC, Fidelity)		
Has Your Active Membership Ended? <input type="checkbox"/> No <input type="checkbox"/> Yes	Have You Withdrawn Accumulated Contributions? <input type="checkbox"/> No <input type="checkbox"/> Yes	Are You Receiving a Retirement Annuity? <input type="checkbox"/> No <input type="checkbox"/> Yes
If You Participated in an Alternate Plan, Provide the Name of the Employer		

III. Employment Information		
APERS Employer Number	APERS Employer Name	
Enrollment Status <input type="checkbox"/> Active Member <input type="checkbox"/> DROP Participant <input type="checkbox"/> Retired Member		
Enrollment Date (mm/dd/yyyy)	Enrollment Reason <input type="checkbox"/> New Hire <input type="checkbox"/> Newly Eligible	If Newly Eligible, Indicate Original Hire Date
Position	Planned Monthly Hours	Hourly Rate

IV. Enrollment Certifications	
<ul style="list-style-type: none"> ▪ I acknowledge that I read the <i>Enrolling in the Retirement System</i> publication which explains the membership and enrollment provisions for employees of participating public employers. ▪ I certify that the enrollment information provided above is true and complete. 	
Employee Signature	Date
Employer Representative Signature	Date



Employee Contributions Beneficiary Designation

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I. Member Information	
Social Security Number	Name (Last, First, Middle Initial)
Mailing Address	City, State, Zip Code
APERS Employer Number	APERS Employer Name

II. Beneficiary Information		
Social Security Number	Name (Last, First, Middle Initial)	
Date of Birth (mm/dd/yyyy)	Relationship	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male

Social Security Number	Name (Last, First, Middle Initial)	
Date of Birth (mm/dd/yyyy)	Relationship	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male

Social Security Number	Name (Last, First, Middle Initial)	
Date of Birth (mm/dd/yyyy)	Relationship	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male

III. Beneficiary Designation Certifications	
<ul style="list-style-type: none"> ▪ I acknowledge that I read the <i>Designating a Beneficiary for Employee Contributions</i> publication which explains the provisions for designating a beneficiary for my employee contributions. ▪ I request the APERS Board of Trustees (Board) to pay the total amount of the accumulated contributions standing to my credit in the System to the person(s) designated above if my death occurs and there is no death-in-service benefit payable. I agree on behalf of myself, heirs and assigns that payment so made be a complete discharge of the claims and constitute a release of the System from any further obligations on account of the benefit. ▪ I hereby direct that should I survive the beneficiary, the amount which otherwise would have been payable to the beneficiary be paid according to the provisions of the retirement act or to such other beneficiary as I hereafter nominate by written designation filed with the System in accordance with the rules and regulations prescribed by the Board. 	
Member Signature	Date
Employer Representative Signature	Date