San Diego Community College District

RETIREMENT SYSTEM STATUS INFORMATION

(Check appropriate box) ☑ ACADEMIC ☐ NON-ACADEMIC

INSTRUCTIONS: Complete this form and return it to the Human Resources-Payroll Office. This information is essential in determining your retirement system status. **Your first pay warrant cannot be prepared until this form has been filed, and errors in information provided may delay your first pay warrant, or could result in a subsequent pay adjustment for recovery of retirement contributions owed.**

NAME (Last, first, middle, maiden or other)	Social Security #	Date of birth

1. Are you currently working or have you ever worked before, in any capacity, for:

			Full-time	Part-time
San Diego Unified School District?.....	☐ Yes	☐ No	☐ Yes	☐ No
San Diego Community College District……	☐ Yes	☐ No	☐ Yes	☐ No
A San Diego County school district?.....	☐ Yes	☐ No	☐ Yes	☐ No
If yes, name district _____				
Another California school district?.....	☐ Yes	☐ No	☐ Yes	☐ No
If yes, name district _____				
Other public agency in California?.....	☐ Yes	☐ No	☐ Yes	☐ No
If yes, name agency _____				

2. Answer the following section, as appropriate.

I contributed to the following systems:
- ☐ None
- ☐ State Teachers' (STRS)
- ☐ Public Employees' (PERS)
- ☐ Other _____

Did you ever get a refund of your contributions? ☐ Yes ☐ No
If so, when? _____

Are you a full-time student attending SDCCD? ☐ Yes ☐ No

Do you have funds on deposit now? ☐ Yes ☐ No
If so, give name of system or systems _____

My job title is/was:	The approximate dates of the above employment are:_____ Are you currently active in this assignment? ☐ Yes ☐ No	If employed under another name please specify:

3. Have you ever been allowed a choice of membership between STRS and PERS? ☐ Yes ☐ No
If yes, when? (approximate) _____
Month/Year

4. Are you currently retired and receiving a monthly allowance from ☐ STRS ☐ PERS ☐ OTHER? _____

I certify that the above information is correct and complete to the best of my knowledge.

Date completed: _____ Signature _____

BE AWARE that employment in either an academic or non-academic capacity in any California school district may require that you become a member of the State Teachers' Retirement System (STRS) or the Public Employees' Retirement System (PERS), as appropriate. Qualification is as follows:

STRS- Part-time academic employees qualify for membership after completing 60 hours in a pay period, or 10 days in a pay period on a daily basis, in one school district.

PERS- Part-time non-academic employees qualify for membership in PERS by working 1,000 hours in a fiscal year

San Diego Community College District
3375 Camino del Rio South, San Diego, CA 92108
People, Culture, and Technology Services [Human Resources] | Payroll Office | Phone: 619-388-6582

Designation of Beneficiary Under Government Code §53245

As provided in Section 53245 of the California Government Code, in the event of my death, I hereby designate the following as the person to receive all warrants or checks that will be payable to me from the District.

Beneficiary #1

Relationship: _____

Name _____ Birthdate: _____

Address: _____

City/State: _____ Zip: _____

Phone: _____ Email: _____

If the person indicated above predeceases me, I hereby designate the following person as a secondary beneficiary:

Beneficiary #2

Relationship: _____

Name _____ Birthdate: _____

Address: _____

City/State: _____ Zip: _____

Phone: _____ Email: _____

I understand that it is my responsibility to keep this designation current, and further, I understand that this designation is ***in addition to and separate from*** the beneficiary designation filed with the State Teachers' Retirement System and/or the California Public Retirement System, or in any other will, codicils or like documents.

This designation form cancels and replaces any designation previously signed for this purpose only and shall remain in effect until a new form is received.

On sufficient proof of identity, the appointing power shall release the warrants or checks to the above designee. The designee who receives a warrant or check is entitled to negotiate is as if the payee.

_____ _____

Employee Name Employee ID

_____ _____

Employee Signature Date

Please note: ***In the event you get married after you have completed this form, per California Probate Code Section 13601, your spouse is beneficiary by default.***

Permissive Membership - Instructions

If you are employed to perform creditable service in a position that is excluded from mandatory membership in the CalSTRS' Defined Benefit (DB) Program, you may use this form to elect DB Program membership at any time while employed to perform creditable service.

A permissive election of membership in the DB Program applies to all future creditable service performed for the same or another employer, including any non-member or CalSTRS Cash Balance Benefit (CB) Program service you are currently performing. You may be entitled to elect coverage by the CB Program or California Public Employees' Retirement System (CalPERS) for future eligible service as allowed by law. Please work with your employer if you believe you are entitled to make one of these elections.

A permissive election of membership in the DB Program is irrevocable. Membership may only be cancelled if you terminate all employment to perform creditable service and refund your accumulated retirement contributions from the CalSTRS DB Program.

SECTION 1: EMPLOYEE INFORMATION (TO BE COMPLETED BY EMPLOYEE)

Provide the following information:

- CalSTRS Client ID* or Social Security Number
- Last Name, First Name and Middle Initial
- Mailing Address**, City, State and Zip Code
- Date of Birth
- Email Address
- Telephone Number

*If you have already been employed to perform creditable service you will have a CalSTRS Client ID, even if you were not formerly a member. Please provide your CalSTRS Client ID, if you have one, in lieu of your Social Security Number.

**To establish residency for tax purposes, we ask that you provide a street address. Be sure to include any street, apartment or suite number. If your post office does not deliver mail to your street address, you may enter your box number instead. If you reside outside the United States, use the CITY – STATE – ZIP field to provide your foreign address. If you receive your mail in care of a third party, enter "c/o" followed by the third party's name and address.

SECTION 2: EMPLOYEE ELECTION (TO BE COMPLETED BY EMPLOYEE)

If you want to elect membership in the CalSTRS DB Program:

- Check the appropriate box
- Provide your requested membership date***

***You will begin contributing to the DB Program as of your membership date. Your membership date can be no earlier than the first day of the pay period in which your election is made, or your first day of employment, whichever is later. Work with your employer to select the most beneficial, valid membership date you are eligible for. Electing an invalid membership date will require a revision to your election form and may result in delayed contributions to CalSTRS.

If you do not want to elect membership in the CalSTRS DB Program at this time, check the appropriate box.

SECTION 3: REQUIRED SIGNATURE (TO BE COMPLETED BY EMPLOYEE)

Sign the form and date your signature.
Return the form to your employer.

SECTION 4: EMPLOYEE POSITION INFORMATION (TO BE COMPLETED BY EMPLOYER)

Provide the position hire date – the date in which the employee was hired to perform creditable service in the position they are making this election for. CalSTRS defers to the employer as to the date in which you consider an employee to be hired. Provide the position title – the title of the position the employee is performing creditable service in.

SECTION 5: EMPLOYER INFORMATION AND CERTIFICATION (TO BE COMPLETED BY EMPLOYER)

Verify the employee is eligible for the requested membership date.

Provide the following information:

- The employer (county or district) name
- County and district code
- Name and title of employer official completing the form

Sign the form and date your signature.
Submit the form to CalSTRS and retain a copy.

Permissive Membership - Instructions

CALSTRS

SUBMIT

This form should be submitted to CalSTRS by the employer. CalSTRS must receive this form within 60 days after the employee's signature date and, if applicable, prior to the submission of contributions.

Secure Employer Website:	Send the completed form to the ES Forms Queue found in the Business Areas dropdown of the Recipient via SEW.
Email to:	Submit this form via email to the esforms@calstrs.com mailbox unless otherwise instructed by your CalSTRS representative. If sending forms to the esforms@calstrs.com mailbox, please remove all Social Security numbers and only provide the Client ID where applicable.
Mail to:	CalSTRS P.O. Box 15275, MS 17 Sacramento, CA 95851-0275

QUESTIONS

Employee – contact your employer

Employer – contact CalSTRS Employer Help

Permissive Membership

ES 0350 REV 04/23

[For CalSTRS' Official Use Only]

California State Teachers' Retirement System
P.O. Box 15275, MS 17
Sacramento, CA 95851-0275
800-228-5453
CalSTRS.com

PERMISSIVE MEMBERSHIP ELECTION AND/OR ACKNOWLEDGEMENT OF RECEIPT OF CALSTRS DEFINED BENEFIT PROGRAM MEMBERSHIP INFORMATION

This form is used to permissively elect membership in the CalSTRS Defined Benefit Program and/or to acknowledge receipt of information provided by an employer about the right to elect membership in the CalSTRS Defined Benefit Program. Please read all instructions before completing the form.

Section 1: Employee Information (to be completed by employee)

Provide either your CalSTRS Client ID or Social Security number.

CLIENT ID

SOCIAL SECURITY NUMBER

LAST NAME

FIRST NAME

MI

ADDRESS (number, street, apt or suite no.)

CITY

STATE

ZIP CODE

DATE OF BIRTH (MM/DD/YYYY)

EMAIL ADDRESS

TELEPHONE

Section 2: Employee Election (to be completed by employee)

Check One:

☐ **I elect membership in the CalSTRS Defined Benefit Program as of:** _____

MEMBERSHIP DATE (MM/DD/YYYY)**

I understand this election applies to all future creditable service performed for any current or future employer unless another election is made as allowed by law. I understand my membership is irrevocable and may only be cancelled by terminating all employment to perform creditable service and receiving a refund of my accumulated retirement contributions from the CalSTRS Defined Benefit Program.

**Membership Date may be no earlier than the first day of the pay period in which the election is made, or the first day of employment, whichever is later. Please work with your employer to select the most beneficial, valid membership date.

☐ **I decline membership in the CalSTRS Defined Benefit Program at this time**

I understand that I can elect membership in the CalSTRS Defined Benefit Program at any time while I am employed to perform creditable service.

ES0350

Section 3: Required Signature (to be completed by employee)

I certify that I have received information from my employer concerning the CalSTRS Defined Benefit Program and understand the criteria for membership in the program.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement, including a false statement regarding my marital status, for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

EMPLOYEE SIGNATURE	DATE (MM/DD/YYYY)

Section 4: Employee Position Information (to be completed by employer)

POSITION TITLE	POSITION HIRE DATE

Section 5: Employer Information and Certification (to be completed by employer)

Required Signature

I certify that the above-named employee was provided information about their right to elect membership in the CalSTRS Defined Benefit Program and, if electing membership, is eligible to elect membership in the CalSTRS Defined Benefit Program as of the membership date provided.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

EMPLOYER OFFICIAL'S SIGNATURE	DATE (MM/DD/YYYY)
EMPLOYER NAME	COUNTY AND DISTRICT CODE
EMPLOYER OFFICIAL'S NAME AND TITLE	

SCHOOLSFIRST
Plan Administration, LLC

3121 FICA Alternative Plan Enrollment Form

FAX COMPLETED FORMS TO: 714.258.4262

Note: Please allow 5-7 business days for the authorization of your request. Missing or incomplete information will result in a delay of your request.

1 Participant Information

First Name | Last Name | Social Security Number (REQUIRED)/ Tax I.D. No | Date of Birth

Street Address | City | State | Zip Code | Daytime Phone Number

School District Listed as Employer on this Account (REQUIRED) | Participant Email Address

2 Beneficiary Designation Information

☐ I am MARRIED and designate my spouse named below to receive ALL death benefits from the Plan.
☐ I am MARRIED and designate the following person(s) to receive death benefits from the Plan (**SPOUSAL CONSENT REQUIRED** – see below). I
☐ am NOT MARRIED and designate the following person(s) to receive any death benefits. I understand that if I marry this is designation becomes void one year after my marriage.

Spouse Name | Spouse SSN | Spouse Email

☐ Primary | Name | SSN | Relationship | %

☐ Secondary | Email Address | Phone Number | Address

☐ Primary | Name | SSN | Relationship | %

☐ Secondary | Email Address | Phone Number | Address

☐ Primary | Name | SSN | Relationship | %

☐ Secondary | Email Address | Phone Number | Address

3 Spousal Consent (Required for Option 2, if married and spouse is not named beneficiary)

I consent to this designation, which eliminates all or part of the benefits otherwise payable to me from the Plan if my spouse dies.

Spouse's Signature | Date | Notary Public | Date

4 Participant Signature

I hereby authorize my employer, after the date signed, to reduce my salary according to my employers 3121 FICA Alternative Plan provisions. Such reductions shall continue until I am no longer eligible to participate in the plan. I also authorized the above stated beneficiary designation changes (if applicable). THIS AGREEMENT WILL REPLACE ALL PRIOR AGREEMENTS.

Participant Signature (Required) | Date

P.O. Box 11547 Santa Ana, CA 92711 | 800.462.8328 ext. 4727 | Fax: 714.258.4262 | pa.schoolsfirstfcu.org

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ **Employee ID#** _____

Employer Name San Diego Comm Coll District **Employer ID#** 95-2644299

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, “Windfall Elimination Provision.”

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, “Government Pension Offset.”

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee _____ **Date** _____

Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security,** is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/online/ssa-1945.pdf. Paper copies can be requested by email at ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

Recipient Designation–Information
One-Time Death Benefit/Cash Balance Lump-Sum Payment

Important: Be sure to read the instructions carefully before completing this form. **If you submit an incomplete form, we will not accept it. In addition, we must receive your form before your death. Be sure to review your form carefully before submitting it.**

If you're a member of the Defined Benefit Program, use this form to designate your one-time death benefit recipient; if you're a participant of the Cash Balance Benefit Program, use this form to designate your lump-sum payment recipient.

Complete and submit this form online using your *my*CalSTRS account for faster processing. You'll receive step-by-step guidance to complete your form correctly, and your form will be submitted automatically.

We must receive your form before your death.

DEFINED BENEFIT PROGRAM MEMBERS

Use this form to designate recipients to receive the one-time benefit that may be payable in the event of your death. If you are an active member at the time of your death, and if you did not elect an option beneficiary to receive a continuing benefit after your death, or you have no spouse, registered domestic partner or children eligible to receive a family or survivor benefit allowance after your death, any accumulated contributions in your account will be paid to your designated recipients.

If your death occurs before retirement, your recipients may be eligible to receive the balance in your Defined Benefit Supplement account as an ongoing annuity or a lump-sum payment. If your death occurs after retirement, your recipients may be eligible for the ongoing annuity you elected at retirement.

This form will not protect your survivor with a lifetime benefit. To provide your survivors with a lifetime benefit, submit the *Preretirement Election of an Option* form when you are eligible to retire.

CASH BALANCE BENEFIT PROGRAM PARTICIPANTS

Use this form to designate recipients to receive the lump-sum payment in the event of your death.

If you are receiving an annuity at the time of your death, the benefit payable is determined based on the annuity you elected.

If your recipient's (other than an entity) share of your account balance is at least $3,500, they may elect to receive an annuity in place of a lump-sum payment.

IMPORTANT FACTS

- After we review your form and determine it is complete, we will send you a confirmation letter. **Be sure to keep the confirmation letter with your important documents.**
- This form remains in effect until either you submit another valid *Recipient Designation* form, or your membership in CalSTRS is terminated by a refund of your accumulated contributions. This form may or may not remain in effect upon a dissolution of marriage or termination of registered domestic partnership, depending on the circumstances. **It is important to keep this form current.**
- If any of your primary recipients predeceases you, or waives or disclaims their interest, the percentage you designated to that recipient will be distributed proportionally to all your remaining primary recipients. If any of your secondary recipients predeceases you, or waives or disclaims their interest, the percentage you designated to that recipient will be distributed proportionally to all your remaining secondary recipients. If we are unable to locate a recipient you designated, we will not distribute the benefit payable until the designated recipient is located and confirmed.
- If you do not have a valid *Recipient Designation* form on file with CalSTRS before your death or if all your designated recipients predecease you, any death benefit payable will be paid to your estate.
- You may change your recipient designations at any time—before or after retirement. There is no fee or financial penalty for changing your designation. Review your designations regularly to ensure we have the most current and accurate information to pay out the benefits according to your wishes.

Recipient Designation–Instructions

One-Time Death Benefit/Cash Balance Lump-Sum Payment

Print clearly in dark ink or type all information requested. Initial all corrections on the form.

Check the appropriate box to identify your CalSTRS membership status. If you are not sure of your CalSTRS membership, see your most recent *Retirement Progress Report*, available on *my*CalSTRS, or call us at 800-228-5453.

If you are both a Defined Benefit Program member and Cash Balance Benefit Program participant and you are designating different recipients for each, you must complete two separate *Recipient Designation* forms.

SECTION 1: MEMBER/PARTICIPANT INFORMATION

Enter your full name, Client ID or Social Security number, complete mailing address, birth date, telephone number and email address.

SECTIONS 2 AND 3: PRIMARY AND SECONDARY RECIPIENTS OR TRUST

You may name a living person, an estate, a trust, a corporation, a charitable organization, a parochial institution or a public entity as your recipient. **Important Note: All information marked with an asterisk (*) is required. We will reject your form if any required field is left blank.**

- **Persons**—To designate a person or persons, check the box and provide full name,* address,* telephone number, Social Security number,* birth date* and relationship. Be sure to indicate the percentage.
- **Organization**—To designate an organization, check the box and enter the name and address of the organization* and the organization's tax identification number.* Include organization contact information whenever possible. Be sure to indicate the percentage.
- **Trust**—To designate a trust, check the box and enter the full name of the trust,* the trustee's name* and address, and the date the trust was created.* CalSTRS will contact the trustee and pay benefits to the trust. You do not need to provide the trust document at this time. Be sure to indicate the percentage.
- **Estate**—To designate your estate, check the box and enter "My Estate" for the recipient's name. Be sure to indicate the percentage.

Check the box on page 3 if additional recipients are listed on an attachment. Identify each as *primary* or *secondary.*

You must designate a percentage for each recipient. If you use percentages, the total must equal 100 percent for the primary recipient section and 100 percent for the secondary recipient section.

SECTION 4: REQUIRED SIGNATURES

Check all boxes that apply, then sign and date your form. If you are married or registered as a domestic partner, your spouse or partner must also sign and date your form acknowledging your recipients and provide their Social Security number and date of birth. For validation purposes, when using *my*CalSTRS the spouse or partner's signature must be submitted in the same format—handwritten or electronic.

If your spouse or registered domestic partner does not sign your form, you must complete the *Justification for Non-Signature of Spouse or Registered Domestic Partner.*

Failure to have the required signatures will result in the rejection of your *Recipient Designation* form.

If you divorced or terminated a registered domestic partnership and a portion of your CalSTRS benefits was awarded to a former spouse or partner, check the box that indicates this. You may need to refer to your settlement agreement. In addition, if your court documents have not been reviewed by CalSTRS, you may be asked to provide them.

SUBMITTING YOUR FORM

myCalSTRS
Complete and submit your form online using *my*CalSTRS. It's easy, fast and secure.

Hand Delivery
Hand deliver your form to a local CalSTRS office (visit CalSTRS.com/forms-drop). **Note:** We must receive your form before your death.

Mailing Address

CalSTRS
P.O. Box 15275, MS 43
Sacramento, CA 95851-0275

Overnight Delivery

If you are using a special mailing service such as UPS or FedEx, send your form to:

CalSTRS
Member Services
100 Waterfront Place
West Sacramento, CA 95605

Fax Delivery
916-414-5783 or 916-414-5784

QUESTIONS

Email your questions using your *my*CalSTRS account or at CalSTRS.com/contactus, or call 800-228-5453.

Recipient Designation

One-Time Death Benefit/Cash Balance Lump-Sum Payment

MS 0002 rev 09/22

CalSTRS
California State Teachers' Retirement System
P.O. Box 15275, MS 43
Sacramento, CA 95851-0275
800-228-5453
CalSTRS.com

*** Your form will be rejected if any required field is left blank.**

This form is for designating recipients to receive the death benefits payable in the event of your death under the CalSTRS Defined Benefit Program and the Cash Balance Benefit Program. Print clearly in dark ink or type all information requested and initial any corrections. If you are not sure of your CalSTRS membership, see your most recent *Retirement Progress Report*, available on *my*CalSTRS, or call us at 800-228-5453. You may complete and submit this form online using your ***my***CalSTRS account for faster processing. You'll receive step-by-step guidance to complete your form correctly, and your form will be submitted automatically.

Check one of the following:

☐ I am a member of the Defined Benefit Program. My recipient designation is for the one-time death benefit payable upon my death.

☐ I am a participant of the Cash Balance Benefit Program. My recipient designation is for the lump-sum payment to be distributed upon my death.

☐ I am a member/participant of both the Defined Benefit and Cash Balance programs. My recipient designation is for the death benefits payable under both programs. (Refer to instructions if recipients are different between programs.)

I hereby revoke any previous designations and designate the following primary recipients—that are living upon my death—to receive equal amounts, unless otherwise specified, as recipients of any benefits payable under the Teachers' Retirement Law at the time of my death. If any of my primary recipients predecease me, or waive or disclaim their interest, the percentage I designated to that recipient will be distributed proportionally to all my remaining primary recipients. If I survive the primary recipients, I designate the secondary recipients—that are living upon my death—to share equally, unless otherwise specified, as recipients for any benefits payable under law at the time of my death. If any of my secondary recipients predecease me, or waive or disclaim their interest, the percentage I designated to that recipient will be distributed proportionally to all my remaining secondary recipients. If I survive all of my named recipients, then any benefit payable at the time of my death will be paid to my estate. I understand this form does not designate a recipient to receive a continuing monthly retirement benefit.

Section 1: Member/Participant Information (*indicates required information)

NAME (LAST, FIRST, INITIAL)*

CLIENT ID OR SOCIAL SECURITY NUMBER*

MAILING ADDRESS*

DATE OF BIRTH (MM/DD/YYYY)*

CITY* **STATE*** **ZIP CODE***

( ) HOME TELEPHONE

EMAIL ADDRESS

Section 2: Primary Recipients (*indicates required information)

Use this area to designate one or more *primary* recipients to receive a death benefit.
Use additional sheets if needed.

FULL NAME OF PERSON, TRUST OR ORGANIZATION*

( ) TELEPHONE

MAILING ADDRESS*

CITY STATE ZIP CODE

☐ Person – Relationship: _____

Gender: ☐ Male ☐ Female ☐ Nonbinary

☐ Organization – Contact Name: _____

☐ Trust

☐ Estate

SOCIAL SECURITY NUMBER/TAXPAYER ID NUMBER/EMPLOYER ID NUMBER*

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)*

PERCENTAGE*
(MUST TOTAL 100% FOR ALL PRIMARY RECIPIENTS)

MS0002

CALSTRS

*** Your form will be rejected if any required field is left blank.**

Section 2: Primary Recipients continued

FULL NAME OF PERSON, TRUST OR ORGANIZATION*

MAILING ADDRESS* ( ) TELEPHONE

CITY STATE ZIP CODE

☐ Person – Relationship:_____
Gender: ☐ Male ☐ Female ☐ Nonbinary
☐ Organization – Contact Name: _____
☐ Trust
☐ Estate

SOCIAL SECURITY NUMBER/TIN/EIN*

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)*

PERCENTAGE*
(MUST TOTAL 100% FOR ALL PRIMARY RECIPIENTS)*

FULL NAME OF PERSON, TRUST OR ORGANIZATION*

MAILING ADDRESS* ( ) TELEPHONE

CITY STATE ZIP CODE

☐ Person – Relationship:_____
Gender: ☐ Male ☐ Female ☐ Nonbinary
☐ Organization – Contact Name: _____
☐ Trust
☐ Estate

SOCIAL SECURITY NUMBER/TIN/EIN*

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)*

PERCENTAGE*
(MUST TOTAL 100% FOR ALL PRIMARY RECIPIENTS)

Section 3: Secondary Recipients (*indicates required information)

Use this area to designate one or more *secondary* recipients to receive a death benefit should all of your primary recipients predecease you. Use additional sheets if needed.

FULL NAME OF PERSON, TRUST OR ORGANIZATION*

MAILING ADDRESS* ( ) TELEPHONE

CITY STATE ZIP CODE

☐ Person – Relationship:_____
Gender: ☐ Male ☐ Female ☐ Nonbinary
☐ Organization – Contact Name: _____
☐ Trust
☐ Estate

SOCIAL SECURITY NUMBER/TIN/EIN*

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)*

PERCENTAGE*
(MUST TOTAL 100% FOR ALL SECONDARY RECIPIENTS)

CALSTRS

*** Your form will be rejected if any required field is left blank.**

Section 3: Secondary Recipients continued

FULL NAME OF PERSON, TRUST OR ORGANIZATION*

MAILING ADDRESS* ( ) TELEPHONE

CITY STATE ZIP CODE

☐ Person – Relationship:_____

Gender: ☐ Male ☐ Female ☐ Nonbinary

☐ Organization – Contact Name: _____

☐ Trust

☐ Estate

SOCIAL SECURITY NUMBER/TIN/EIN*

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)*

PERCENTAGE *
(MUST TOTAL 100% FOR ALL SECONDARY RECIPIENTS)

☐ **Check this box if additional recipients are listed on an attachment. Identify each as *primary* or *secondary* and the percentages. Percentages must total 100% for all recipients. Important Note: All information marked with an asterisk is required. We will reject your form if any required field is left blank.**

Section 4: Required Signatures

Check all that apply.

☐ I am married or registered as a domestic partner and both our signatures are below.

☐ I am married or registered as a domestic partner and my spouse or partner did not sign below. I have completed and signed the *Justification for Non-Signature of Spouse or Registered Domestic Partner* section on the next page.

☐ I have never been married or in a registered domestic partnership, **or** I am widowed or my partner has died.

☐ I have been divorced or terminated a registered domestic partnership and my former spouse or partner was awarded a portion of my CalSTRS benefits.

☐ I have been divorced or have terminated a registered domestic partnership and my former spouse or partner was *not* awarded a portion of my CalSTRS benefits.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement, including a false statement regarding my marital status, for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

MEMBER'S SIGNATURE **SIGNATURE DATE (MM/DD/YYYY)**

SPOUSE'S OR REGISTERED DOMESTIC PARTNER'S SIGNATURE **SIGNATURE DATE (MM/DD/YYYY)**

SPOUSE'S OR PARTNER'S PRINTED NAME (LAST, FIRST, INITIAL)

SPOUSE'S OR PARTNER'S SOCIAL SECURITY NUMBER SPOUSE'S OR PARTNER'S DATE OF BIRTH (MM/DD/YYYY)

CALSTRS
HOW WILL YOU SPEND YOUR FUTURE?

*** Your form will be rejected if any required field is left blank.**

Justification for Non-Signature of Spouse or Registered Domestic Partner

As required by Education Code sections 22453 and 26703, the signature of the spouse or registered domestic partner of the CalSTRS member or participant is required on any form in which the CalSTRS member or participant makes a request related to the election, change or cancellation of a CalSTRS benefit, subject to the following exceptions. If you are married or registered as a domestic partner and your spouse or partner did not sign one or more of the forms identified in the "Documents Submitted" section, you must check the appropriate box indicating the reason your spouse or partner did not sign.

- ☐ I do not know and have taken all reasonable steps to determine the whereabouts of my spouse or registered domestic partner.
- ☐ My spouse or registered domestic partner is incapable of executing the acknowledgment because of an incapacitating mental or physical condition.
- ☐ My current spouse or registered domestic partner has no identifiable community property interest in the benefits.
- ☐ My spouse or registered domestic partner and I have executed a settlement agreement that makes the community property law inapplicable to the marriage or registered domestic partnership.
- ☐ My spouse or registered domestic partner has refused to sign the acknowledgment. Court action will be or has been initiated to enforce or waive the signature requirement for my spouse or registered domestic partner (Education Code sections 22454 and 26704). CalSTRS must have a certified copy of the court order before any benefits can be paid. Submit a certified copy of the court order when you receive it.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement, including a false statement regarding my marital status, for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

MEMBER'S SIGNATURE **SIGNATURE DATE (MM/DD/YYYY)**

If you submit an incomplete form, we will not accept it. Be sure to review your form carefully before submitting it:

- ☐ Did you designate at least one primary recipient and provide all the required information?
- ☐ If you designated a trust, did you provide the name and date the trust was created? Do not provide your trust document at this time.
- ☐ If you designated percentages, do they equal 100 percent for your primary recipients and 100 percent for your secondary recipients?
- ☐ Did you sign and date the form?
- ☐ If you are married or in a registered domestic partnership, did your spouse or partner sign and date the form?
- ☐ If you cannot obtain your spouse or partner's signature, did you complete, sign and date the *Justification for Non-Signature of Spouse or Registered Domestic Partner*?

SDCCD FACULTY/STAFF PARKING PERMIT APPLICATION

Please print clearly in ink. Return completed application to a location below, to DSC/Parking through District mail or e-mail to parking@sdccd.edu.

PERSONAL INFORMATION: Employee I.D. _____ Faculty ☐ Staff ☐

Name: _____
LAST FIRST MI

_____ _____
WORK/CONTACT PHONE E-MAIL ADDRESS

VEHICLE INFORMATION: Auto ☐ Motorcycle ☐

_____/_____ _____/_____
LICENSE PLATE STATE MAKE MODEL

_____/_____ _____/_____
LICENSE PLATE STATE MAKE MODEL

WORK LOCATION:
(Select ONE)

Your permit will be available for pick-up at the location checked below in 2 weeks.

☐ Mesa Police Q100
☐ City Police V100
☐ Miramar Police T100
☐ Mid City ☐ North City
☐ West City
☐ Cesar Chavez
☐ ECC
☐ DSC/Facilities
☐ DSC/Parking Services
☐ District Office
Room # _____

SDCCD STUDENT HOURLY EMPLOYEES ARE NOT ENTITLED TO STAFF PERMITS

TEMPORARY AND/OR NON-DISTRICT PERSONNEL: ***(semester permits only)***

For the following Semester: ☐ Fall ☐Spring ☐ Summer ☐ Intersession

☐ NANCE, ☐ Intern or ☐ Volunteer for Program Name: _____

☐ Vendor Company Name: _____

☐ Non-District Employee/Independent Contractor (1 Year Permits)

Company Name: _____Office #_____

APPROVAL SIGNATURE REQUIRED FOR ALL ABOVE PERSONNEL

Supervisor Signature: _____ Date: _____

Printed Name: _____ Supervisor Phone: _____

OFFICE USE ONLY:

I RECEIVED MY PERMIT ON (DATE): _____ **EMPLOYEE SIGNATURE:** _____

Identification furnished: ☐ **CDL** ☐ **Other:** _____ **Police Employee Initials:** _____

PERMIT #: PERMIT TYPE: ISSUED ON: BY: VALID THRU: