



STATE OF DELAWARE
MEMBER ACTUARIAL INFORMATION

PERSONAL DATA:

To be completed by Member (Please Print)

1. _____ 2. Soc. Sec. No.: _____
 (Last Name) (First Name) (M.I.) (Maiden Name)
3. Address: _____ 4. Telephone No.: _____
 (Number) (Street) (City) (State) (Zip Code)
5. Date of Birth: _____ 6. Gender: Male Female 7. Marital Status: Married Civil Union Single
 (Month / Day / Year) (Choose One) (Choose One)
8. Organization: _____ Department ID: _____
9. Pension Plan: (Check One): State Employees' State Police: Judiciary: Legislative:
 C/M Police/Fire: C/M General: (LOSAP) Fire: Port:
10. Effective Date of Hire with Present Organization: _____ 11. Current Annual Salary: _____
12. Have you previously been a member of any State of Delaware State Sponsored Pension Plan: Yes No If YES, complete list below:

(INCLUDE LEAVES OF ABSENCE
 AND INDICATE REASON)

NAME OF ORGANIZATION	FROM		THROUGH		PERIOD COVERED	
	MONTH	YEAR	MONTH	YEAR	YEARS	MONTHS
TOTAL PRIOR SERVICE CLAIMED	(ADD)					

13. (a) Did you serve in the Armed Forces of the United States: Yes No
 (b) If (a) is YES, show total Active Military Service:
 FROM _____ TO _____ TOTAL CREDIT _____
 (c) Did you begin a full-time vocational or professional training course within 5 years of your discharge and become a State employee within 5 years after the completion of that training: Yes No
 (d) If (c) is YES, show full-time vocational or professional training course dates, and date degree, diploma, or certificate granted:
 FROM _____ TO _____ DATE OF DEGREE _____

14. Have you ever rendered full-time service in professional educational employment or other full-time employment for another State or the Federal Government, a county or municipality of the State of Delaware, a political subdivision of another State, or in an accredited private school or college: Yes No If YES, complete list below:

NAME OF ORGANIZATION	FROM		THROUGH		PERIOD COVERED	
	MONTH	YEAR	MONTH	YEAR	YEARS	MONTHS

15. Are you eligible for benefits as a result of any service listed in No. 14 above: Yes No

DEPENDENT DATA: (This information must be filled out if you are married or in a civil union.)

16. Name of Spouse: _____ Gender: Male Female
 (Last Name) (First Name) (M.I.) (Maiden Name)
- _____ Telephone No.: _____
 (Street Address) (City) (State) (Zip)
- Date of Birth: _____ Soc. Sec. No.: _____ Date of Marriage/Civil Union: _____
 (Month/Day/Year) (Month/Day/Year)

17. Dependent Child(ren) or Dependent Parents (Fill in only if parent(s) are receiving at least one-half of his or her support from you) :

(Month/Day/Year)

Name: _____ Date of Birth: _____ Soc. Sec. No.: _____

Address: _____ Telephone No.: _____

Gender: Male Female Disabled: Yes No Dep. Child: _____ Dep. Parent: _____ Relationship: _____
(Month/Day/Year)

Name: _____ Date of Birth: _____ Soc. Sec. No.: _____

Address: _____ Telephone No.: _____

Gender: Male Female Disabled: Yes No Dep. Child: _____ Dep. Parent: _____ Relationship: _____
(Month/Day/Year)

Name: _____ Date of Birth: _____ Soc. Sec. No.: _____

Address: _____ Telephone No.: _____

Gender: Male Female Disabled: Yes No Dep. Child: _____ Dep. Parent: _____ Relationship: _____
(Month/Day/Year)

Name: _____ Date of Birth: _____ Soc. Sec. No.: _____

Address: _____ Telephone No.: _____

Gender: Male Female Disabled: Yes No Dep. Child: _____ Dep. Parent: _____ Relationship: _____

**DESIGNATION OF BENEFICIARY FOR PAYMENT OF PENSION CONTRIBUTIONS
IF NO SURVIVOR'S PENSION IS PAYABLE**

18. (If more than one name is listed, payment will be divided equally, unless otherwise specified.)

Primary/Contingent (Month/Day/Year)

Name: _____ Date of Birth: _____ SSN or EIN: _____

Address: _____ Telephone No.: _____

Relationship: _____ Gender: Male Female

Primary/Contingent (Month/Day/Year)

Name: _____ Date of Birth: _____ SSN or EIN: _____

Address: _____ Telephone No.: _____

Relationship: _____ Gender: Male Female

Primary/Contingent (Month/Day/Year)

Name: _____ Date of Birth: _____ SSN or EIN: _____

Address: _____ Telephone No.: _____

Relationship: _____ Gender: Male Female

Primary/Contingent (Month/Day/Year)

Name: _____ Date of Birth: _____ SSN or EIN: _____

Address: _____ Telephone No.: _____

Relationship: _____ Gender: Male Female

19. I hereby certify that all information given is accurate and true to the best of my knowledge and belief.

DATE: _____ SIGNATURE OF MEMBER: _____