|  |
| --- |
| **APPLICATION FOR DEFERRED RETIREMENT OPTION PLAN** |
| **Arkansas State Highway Employees’ Retirement System**Highway Department BuildingP.O. Box 2261Little Rock, AR 72203(501) 569-2411 |
| I, |       |  | Social Security Number |       |
|  | (Please Print Name) |  |  |  |
| hereby make application for participation in the Deferred Retirement Option Plan (DROP) in accordance with Act 1073 of 1997. I understand “DROP” is an optional method for retiring from the Arkansas State Highway Employees’ Retirement System without a break in service. |
|  |
| I UNDERSTAND MY ELECTION TO PARTICIPATE is a voluntary benefit and **irrevocable**. I acknowledge that the provisions of the DROP program have been explained to me, and **I am not entitled to any additional service credit for my period of DROP participation.**  |
|  |
| **ACT 776 of 2003** allows a member to participate in the DROP until the later of age sixty-five or the fifth anniversary of their entry date. I understand that after the initial 5 years I will no longer be exempt from retirement contributions and will pay the current rate of 6% of my gross salary to the System with no additional benefit to me. I understand that the amount deposited into my DROP during this period shall be cost neutral to the system as determined by the system’s actuary.  |
|  |
| **CONTRIBUTIONS WILL NOT BE** **DEDUCTED FROM YOUR GROSS WAGES DURING THE FIRST 5 YEARS OF DROP PARTICIPATION BUT WILL RESUME IF YOU ARE ELIGIBLE AND CHOOSE TO STAY IN THE PLAN OVER 5 YEARS.** |
|  |
|  |  |  |  |  |
|  | (Applicant’s Signature) |  |  | (Date) |
|  |
|  |
| The effective date of my participation in DROP will be |       |    | , |      | . |
|  | (Month) | (Day) |  | (Year) |  |
|  |
|  |
| ***FORM MUST BE NOTARIZED BELOW*** |  |  |
|  |  |
| State of  |  | County of  |  |  |  |
|  |  |  |  |  |  |  |
| Subscribed and sworn to before me on this |  | day of  |  | , |  | . |  |
|  |  |  |  |  |  |
|  |  |  | Notary Public |  |  |
|  | (SEAL) |  |
|  |   |  | My commission expires |  |
|  |  |
|  |  | *Applicant’s Signature* |  |
|  |  |  |  | ***(to be signed in front of notary)*** |
|  |
| **TO BE COMPLETED BY ASHERS** |
|  |
|  |
| This is to verify that the above named employee has made application to participate in the Deferred Retirement Option Plan. |
|  |
|  |
|  |  |  |  |  |  |
|  | (Retirement Official) | (Date) |  |  | (Title) |