FORM WB-1
(Rev. 8/06)

STATE OF DELAWARE

STATE BOARD OF PENSION TRUSTEES
AND
OFFICE OF PENSIONS

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DELAWARE PUBLIC EMPLOYEES' RETIREMENT SYSTEM
APPLICATION FOR WITHDRAWAL BENEFIT

I, _____, Social Security #: _____

have terminated my employment with _____
(Name of Agency/School)

effective _____. I hereby request to receive a withdrawal benefit of the accumulated pension contributions, plus interest, standing to my credit in the Delaware Public Employees' Retirement System. I understand that pursuant to Rule and Regulation #50.10 my accumulated contributions, with interest, shall not be paid until the expiration of at least **three (3) months following the date of my last payroll check received.** I also understand that if the taxable portion of my refund exceeds $200.00, I will need to file a Rollover Election Form with the Office of Pensions. If I do not receive these forms 30 days prior to my scheduled refund date, I will contact the Office of Pensions.

I understand that if I terminated before 6/30/76 with twenty (20) years of credited State service or I terminated after 6/30/76 but before 6/30/88 with ten (10) years of credited State service or I terminated after 6/30/88 with five (5) years of credited State service, I have accrued a vested right to a pension commencing at age sixty-two (62); however, this vested right is forfeited upon submitting this application and receiving a refund of my accumulated contributions.

I further understand that the **withdrawal of these contributions terminates my membership in the Retirement Plan and that if I later return to State service as a covered employee, I must, in order to reinstate my prior service credits, repay the total amount withdrawn plus interest**, at the rate established by the State Board of Pension Trustees.

*A **CLEAR** COPY OF YOUR VALID DRIVER'S LICENSE OR PICTURE ID IS **REQUIRED** WITH THIS APPLICATION.

Signature _____ Date _____

Address _____ Phone # _____

_____ Zip Code _____

If name has been changed, enter former name here and provide documentation: _____

THE FOLLOWING TO BE COMPLETED BY AGENCY/SCHOOL

I hereby certify that the above applicant has terminated with this agency/school effective _____.
I FURTHER CERTIFY THAT THERE ARE NO PAYROLL CHECKS PENDING CANCELLATION. The employee's final paycheck was/will be _____.

_____	_____	_____
Authorized Signature	**Title**	**Date**

Agency/School Name: _____ **Agency/School DDS#:** _____