

STATE OF DELAWARE
STATE BOARD OF PENSION TRUSTEES
AND
OFFICE OF PENSIONS
MCARDLE BUILDING
860 SILVER LAKE BLVD., SUITE 1
DOVER, DE 19904-2402

Return to
Pension Office

When Calling Long Distance
Toll Free Number 1-800-722-7300
E-mail: pensionoffice@state.de.us

Telephone (302) 739-4208
FAX # (302) 739-6129
www.delawarepensions.com

DELAWARE PUBLIC EMPLOYEES' RETIREMENT SYSTEM
APPLICATION FOR WITHDRAWAL BENEFIT

I, _____, Social Security #: _____

have terminated my employment with _____
(Name of Organization)

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 (DPERS). I understand my accumulated contributions, with interest, shall not be paid until the Office of Pensions has verified the employee's total pension contribution (normally forty-five (45) days after the date of the last payroll check). I also understand that if the taxable portion of my refund exceeds \$200.00, I will need to file a Payment Disbursement Election Form (which will be mailed from the Office of Pensions within 7 business days of receipt of this WB-1 form). 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 terminate with a vested right to a pension, this vested right, as well as any obligation by DPERS to provide any further benefits or coverage, 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 DPERS 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to State service as a covered employee, I must, in order to reinstate my prior service credits, repay the total amount withdrawn plus interest**, at the rate established by the State Board of Pension Trustees.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** (ENLARGED) COPY OF YOUR VALID DRIVER'S LICENSE OR PICTURE ID IS **REQUIRED** WITH THIS APPLICATION.

Signature _____ Date _____

Address _____ Phone # _____

_____ Zip Code _____

If name has changed, enter former name here: _____. Also, please submit a copy of your Social Security card as it will be **REQUIRED** to process your name change.

ORGANIZATION REQUIREMENT

The above applicant has indicated that he/she has terminated pension creditable employment with your organization and is requesting a refund of pension contributions.

Please submit a Pension Creditable Compensation (PCC-1) form as soon as possible.

We will be unable to process this refund until the PCC-1 is received.