STATE OF DELAWARE
OFFICE OF PENSIONS

JOINT AND SURVIVOR BENEFIT FORM

PLEASE COMPLETE AND RETURN FORM TO PENSION.FORMS@DELAWARE.GOV

First Name & Middle Initial: _____Last Name: _____

Pension ID: _____

Pension Plan: Check One

☐ State Employees'
☐ State Police
☐ Legislators'
☐ Judiciary
☐ County Municipal General
☐ County Municipal Police and Fire

In accordance with 11 Del. C. § 8368, 11 Del. C. § 8821A, 29 Del. C. § 5527(g), 29 Del. C. § 5577, and 29 Del. C. § 5613(3), the employee must complete this form prior to the issuance of the first pension check even if you do not have an eligible survivor. Once this election has been made, it shall be **IRREVOCABLE and cannot be changed for any reason including any future change in the pensioner's survivor, marital, or dependent status**.

The purpose of this form is for you to choose the percentage of the monthly pension that you would like to leave to your eligible survivor(s) at the time of your death (an eligible survivor is your spouse, dependent children under 18, children 18 to 22 that are full time students, a child that is permanently disabled as a result of a disability which began before the child attained age 18, or your dependent parents).

☐ I elect a survivor's monthly pension equal to 50% of the service or disability pension benefit that I will be receiving at the time of my death. This is an option that could be chosen if you have no eligible survivors and expect to have no eligible survivors in the future. Under this election, my service or disability pension will not be reduced.

☐ I elect to reduce my service or disability pension by 2% to provide a survivor's monthly pension equal to 66.67% of the reduced service or disability pension that I will be receiving at the time of my death.

☐ I elect to reduce my service or disability pension by 3% to provide a survivor's monthly pension equal to 75% of the reduced service or disability pension that I will be receiving at the time of my death.

☐ I elect to reduce my service or disability pension by 6% to provide a survivor's monthly pension equal to 100% of the reduced service or disability pension that I will be receiving at the time of my death.

Your signature on this form must be notarized.
Do not sign this form until you are in the presence of the notary public.

Signature _____ Phone _____

For use by Notary Public Only
Sworn to and Subscribed before me the _____day of _____, 20_____.

Signature of Notary Public _____

Place Notary Stamp Here:

My Commission Expire: