STATE OF DELAWARE
OFFICE OF PENSIONS

PENSION CREDITABLE COMPENSATION (AGENCY)

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

The Pension Office is responsible for verifying creditable compensation and wages subject to pension contributions; therefore, this form must be completed for all employees who have terminated, deceased, or who have retired on a service, disability or vested pension.

First Name & Middle Initial: _____ Last Name: _____

Pension ID or SSN: _____

Date of: ☐ Retirement ☐ Death ☐ Termination _____

Last Day Worked (If different from above): _____

Indicate number of hours worked per day if not 7.5 hours: _____

Amount of Last Regular Pay:

Regular – Salary: ---------- _____

Overtime: ---------- _____

Holiday: ---------- _____

Comp Time Amount: ---------- _____

Date / Timeframe Earned: ---------- _____

Shift Differential: ---------- _____

Hazard Duty: ---------- _____

Other: ---------- _____

Total of Last Regular Pay: _____

Date Disbursed: _____

860 SILVER LAKE BLVD., SUITE 1 - MCARDLE BUILDING - DOVER, DE 19904 / SLC D570A
PHONE: (302) 739-4208 - TOLL FREE: (800) 722-7300 - FAX: (302) 739-6129
EMAIL: PENSIONOFFICE@DELAWARE.GOV - WWW.DELAWAREPENSIONS.COM

Amount of Paid Sick Leave:

Number of hours accrued: _____

Total number of hours paid: _____ x Hourly rate _____ Total: _____

Date Distributed: _____

Amount of Paid Vacation Leave:

Number of hours accrued: _____

Total number of hours paid: _____ x Hourly rate _____ Total: _____

Date Distributed: _____

I CERTIFY THAT THERE ARE NO PAYROLL ADJUSTMENTS PENDING.

Authorized Signature _____

Title _____ Date _____

Print Name: _____

Agency Name: _____