Form No. P-1 (2/19)
Email: pensionoffice@delaware.gov
www.delawarepensions.com
Toll Free Number
Outside State of Delaware
1 - 800 - 722 – 7300

Office of Pensions
McArdle Building
860 Silver Lake Blvd, Suite 1
Dover, DE 19904-2402
Telephone: (302) 739 - 4208

STATE OF DELAWARE

MEMBER ACTUARIAL INFORMATION

Reset Form

PERSONAL DATA: To be completed by Member (Please Print)

1. _____ 2. Soc. Sec. No.: _____
(Last Name) (First Name) (M.I.) (Maiden Name)

3. Address: _____ 4. Telephone No.: _____
(Number) (Street) (City) (State) (Zip Code)

5. Date of Birth: _____ (Month / Day / Year) 6. Gender: ☐ Male ☐ Female (Choose One) 7. Marital Status: ☐ Married ☐ Civil Union ☐ Single (Choose One)

8. Organization: _____ Department ID: _____

9. Pension Plan: (Check One): State Employees': ☐ State Police: ☐ Judiciary: ☐ Legislative: ☐
C/M Police/Fire: ☐ C/M General: ☐ (LOSAP) Fire: ☐ Port: ☐

10. Effective Date of Hire with Present Organization: _____ 11. Current Annual Salary: _____

12. Have you previously been a member of any State of Delaware State Sponsored Pension Plan: Yes ☐ No ☐ If YES, complete list below:

PRIOR SERVICE CLAIMED (INCLUDE LEAVES OF ABSENCE AND INDICATE REASON)

NAME OF ORGANIZATION	FROM MONTH	FROM YEAR	THROUGH MONTH	THROUGH YEAR	PERIOD COVERED YEARS	PERIOD COVERED MONTHS
TOTAL PRIOR SERVICE CLAIMED				(ADD)		

13. (a) Did you serve in the Armed Forces of the United States: Yes ☐ No ☐
(b) If (a) is YES, show total Active Military Service:

FROM _____ TO _____ TOTAL CREDIT _____

(c) Did you begin a full-time vocational or professional training course within 5 years of your discharge and become a State employee within 5 years after the completion of that training: Yes ☐ No ☐
(d) If (c) is YES, show full-time vocational or professional training course dates, and date degree, diploma, or certificate granted:

FROM _____ TO _____ DATE OF DEGREE _____

14. Have you ever rendered full-time service in professional educational employment or other full-time employment for another State or the Federal Government, a county or municipality of the State of Delaware, a political subdivision of another State, or in an accredited private school or college: Yes ☐ No ☐ If YES, complete list below:

NAME OF ORGANIZATION	FROM MONTH	FROM YEAR	THROUGH MONTH	THROUGH YEAR	PERIOD COVERED YEARS	PERIOD COVERED MONTHS

15. Are you eligible for benefits as a result of any service listed in No. 14 above: Yes ☐ No ☐

DEPENDENT DATA: (This information must be filled out if you are married or in a civil union.)

16. Name of Spouse: _____ Gender: ☐ Male ☐ Female
(Last Name) (First Name) (M.I.) (Maiden Name)

_____ Telephone No.: _____
(Street Address) (City) (State) (Zip)

Date of Birth: _____ (Month/Day/Year) Soc. Sec. No.: _____ Date of Marriage/Civil Union: _____ (Month/Day/Year)

17. Dependent Child(ren) or Dependent Parents (Fill in only if parent(s) are receiving at least one-half of his or her support from you) :

(Month/Day/Year)

Name: ______________________ Date of Birth: __________ Soc. Sec. No.: ______________

Address: ______________________ Telephone No.: ______________

Gender: ☐ Male ☐ Female Disabled: ☐ Yes ☐ No Dep. Child: ☐ Dep. Parent: ☐ Relationship: ______________

(Month/Day/Year)

Name: ______________________ Date of Birth: __________ Soc. Sec. No.: ______________

Address: ______________________ Telephone No.: ______________

Gender: ☐ Male ☐ Female Disabled: ☐ Yes ☐ No Dep. Child: ☐ Dep. Parent: ☐ Relationship: ______________

(Month/Day/Year)

Name: ______________________ Date of Birth: __________ Soc. Sec. No.: ______________

Address: ______________________ Telephone No.: ______________

Gender: ☐ Male ☐ Female Disabled: ☐ Yes ☐ No Dep. Child: ☐ Dep. Parent: ☐ Relationship: ______________

(Month/Day/Year)

Name: ______________________ Date of Birth: __________ Soc. Sec. No.: ______________

Address: ______________________ Telephone No.: ______________

Gender: ☐ Male ☐ Female Disabled: ☐ Yes ☐ No Dep. Child: ☐ Dep. Parent: ☐ Relationship: ______________

DESIGNATION OF BENEFICIARY FOR PAYMENT OF PENSION CONTRIBUTIONS IF NO SURVIVOR'S PENSION IS PAYABLE

18. (If more than one name is listed, payment will be divided equally, unless otherwise specified.)

Primary/Contingent (Month/Day/Year)

☐ ☐ Name: ______________________ Date of Birth: __________ SSN or EIN: __________

Address: ______________________ Telephone No.: __________

Relationship: __________ Gender: ☐ Male ☐ Female

Primary/Contingent (Month/Day/Year)

☐ ☐ Name: ______________________ Date of Birth: __________ SSN or EIN: __________

Address: ______________________ Telephone No.: __________

Relationship: __________ Gender: ☐ Male ☐ Female

Primary/Contingent (Month/Day/Year)

☐ ☐ Name: ______________________ Date of Birth: __________ SSN or EIN: __________

Address: ______________________ Telephone No.: __________

Relationship: __________ Gender: ☐ Male ☐ Female

Primary/Contingent (Month/Day/Year)

☐ ☐ Name: ______________________ Date of Birth: __________ SSN or EIN: __________

Address: ______________________ Telephone No.: __________

Relationship: __________ Gender: ☐ Male ☐ Female

19. I hereby certify that all information given is accurate and true to the best of my knowledge and belief.

Print Form

DATE: ______________ **SIGNATURE OF MEMBER:** ______________________