Form No. P-1 (10/12)
Email: pensionoffice@state.de.us
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

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: _____ 6. Gender: Male OR Female 7. Marital Status: Married Civil Union Single
(Month / Day / Year) (Circle One) (Circle 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, 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, 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:

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

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

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

17. Unmarried Dependent Child(ren):

Name: ______________________ Date of Birth: ____________ Soc. Sec. No.: ______________
(Month/Day/Year)
Address: ______________________________________ Telephone No.: ______________

Gender: Male / Female Disabled: Yes / No

Name: ______________________ Date of Birth: ____________ Soc. Sec. No.: ______________
(Month/Day/Year)
Address: ______________________________________ Telephone No.: ______________

Gender: Male / Female Disabled: Yes / No

Name: ______________________ Date of Birth: ____________ Soc. Sec. No.: ______________
(Month/Day/Year)
Address: ______________________________________ Telephone No.: ______________

Gender: Male / Female Disabled: Yes / No

Name: ______________________ Date of Birth: ____________ Soc. Sec. No.: ______________
(Month/Day/Year)
Address: ______________________________________ Telephone No.: ______________

Gender: Male / Female Disabled: Yes / No

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

Father's Name: ______________________________________
(Last Name) (First Name) (M.I.)
Address: ______________________________________

Date of Birth: ____________ Soc. Sec. No.: ______________ Telephone No.: ________ ______________
(Month/Day/Year)

Mother's Name: ______________________________________
(Last Name) (First Name) (M.I.)
Address: ______________________________________

Date of Birth: ____________ Soc. Sec. No.: ______________ Telephone No.: ______________
(Month/Day/Year)

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

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

Primary/Contingent
☐ ☐ Name: ______________________ Date of Birth: ____________ Soc. Sec. No.: ____________
(Month/Day/Year)

Address: ______________________________________ Telephone No.: ____________

Relationship: ____________ Gender: Male / Female

Primary/Contingent
☐ ☐ Name: ______________________ Date of Birth: ____________ Soc. Sec. No.: ____________
(Month/Day/Year)

Address: ______________________________________ Telephone No.: ____________

Relationship: ____________ Gender: Male / Female

Primary/Contingent
☐ ☐ Name: ______________________ Date of Birth: ____________ Soc. Sec. No.: ____________
(Month/Day/Year)

Address: ______________________________________ Telephone No.: ____________

Relationship: ____________ Gender: Male / Female

Primary/Contingent
☐ ☐ Name: ______________________ Date of Birth: ____________ Soc. Sec. No.: ____________
(Month/Day/Year)

Address: ______________________________________ Telephone No.: ____________

Relationship: ____________ Gender: Male / Female

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

DATE: ______________ **SIGNATURE OF MEMBER:** ______________________________