

REQUEST FOR COSTS TO PURCHASE SERVICE CREDIT

Use this form to request the costs to purchase SDCERA service credit. Verification of service must occur before any service credit may be purchased. Please allow 6 to 8 weeks to receive a response from SDCERA and up to 12 weeks (for sick leave without pay or prior public agency service contract requests). If verification from your payroll representative or previous employer is required and delayed, it will cause a delay in processing time. In addition, incomplete verification will be returned to you to obtain the required information. SDCERA will not begin processing your request until complete verification is received.

MEMBER INFORMATION

Name (last, first, middle initial)	Social Security number
Mailing address (street or PO box)	Birth date (mo/day/yr)
City, State, ZIP	Daytime telephone number
Previous name(s) used	Estimated retirement date (mo/day/year)*
Spouse/registered domestic partner's birth date (mo/day/year)	

*Your estimated retirement date is necessary to show you how the service credit purchase may affect your retirement benefit.

TYPE OF SDCERA SERVICE CREDIT REQUESTED

Please indicate the type of contract you are requesting by selecting either a new contract, or an update to a previous contract that has expired.

- Redeposit of withdrawn contributions:** calculate new contract update previous contract
worked from _____ to _____ (record dates)
- Service prior to membership:** calculate new contract update previous contract
worked from _____ to _____ (record dates)
- Sick leave without pay:** calculate new contract update previous contract

<i>If your request is for a sick leave without pay contract, you must have the payroll representative (from the department you worked in during your leave) complete this section before you submit this form to SDCERA.</i>		
Member was on leave from _____ to _____ (record dates)		
Reason for leave without pay: <input type="checkbox"/> Personal illness <input type="checkbox"/> Injury <input type="checkbox"/> Maternity leave	Total hours of sick leave without pay: _____ Total hours of family medical care leave: _____ Total hours of miscellaneous leave: _____ <i>Hours noted are hours due to personal leave without pay and do not include leave used to care for a family member. (Attach back-up as needed.)</i>	Additional comments:
Payroll representative's full name		Payroll representative's title
Payroll representative's signature	Payroll representative's telephone number	Date

- Prior public agency:** calculate new contract update previous contract

Full name of previous employer _____
worked from _____ to _____ (record dates)

If your request is for a prior public agency contract, SDCERA will forward you an additional verification form to complete and forward upon receipt of this initial request.

Member signature _____ Date _____