



## APPLICATION FOR REFUND OF PENSION PLAN CONTRIBUTIONS - GSEPS

1. Please print or type clearly.
2. This application is for pension plan refunds only. To request a distribution or rollover of your 401(k) plan, access your account at [www.GaBreeze.ga.gov](http://www.GaBreeze.ga.gov) or call 1-877-342-7339.
2. Send this form to your Payroll Department. **Do not send to Employees' Retirement System (ERS).**
3. If the taxable portion (interest earned) of your refund is *less* than \$200.00, ERS will withhold federal income tax. Typically the rate is 30%, or if you are over 59 1/2, the withholding rate is 20%.
4. If the taxable portion (interest earned) of your refund is *more* than \$200.00, ERS is required to withhold federal income tax unless you directly roll over the taxable portion to another eligible retirement plan. You will be notified by ERS if this applies to you.

### SECTION 1 - MEMBER INFORMATION

Name: \_\_\_\_\_ SSN:

(Last) (First) (MI) (Maiden)

Mailing Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ E-mail : \_\_\_\_\_ Daytime Phone No: (\_\_\_\_) \_\_\_\_\_  
(mm) (dd) (yyyy)

State Agency/Department in which you were employed: \_\_\_\_\_

### SECTION 2 - MEMBER SIGNATURE

**I understand that by receiving this refund I waive all rights to benefits accrued from the GSEPS ERS pension plan.**

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### SECTION 3 - PERSONNEL/PAYROLL USE ONLY

1. Please provide the following dates for the above mentioned employee (if applicable).

Termination date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Military Leave: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ LWOP: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Complete salary & contributions information for the current fiscal year.

MONTH	SALARY	CONTRIBUTIONS
July		
August		
September		
October		
November		
December		
January		
February		
March		
April		
May		
June		
<b>TOTALS:</b>		

3. Read the statement below and sign.

This employee has terminated with this Department. I certify that these amounts are the total and final employee and employer-paid contributions for the current and/or prior fiscal year.

\_\_\_\_\_  
Payroll Officer Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number

### FOR ERS USE ONLY - PRIOR YEAR'S INFO

Total # of Months: \_\_\_\_\_ Total Salary: \_\_\_\_\_ Total Contributions: \_\_\_\_\_