STATE OF HAWAII
PTS DEFERRED COMPENSATION RETIREMENT PLAN
for Part-Time, Temporary, and Seasonal/Casual Employees
(Participating Employers include: State of Hawaii and County of Kauai)

ENROLLMENT FORM for the following Employer:

☐ State of Hawaii ☐ County of_____

Please type or print in ink. Complete ALL information. Failure to complete and return this form may delay or prevent receiving your distribution check after you separate from service.

Send your completed form to:
National Benefits Services, LLC, P.O. Box 6980, West Jordan, UT 84084

SECTION I – IDENTIFYING EMPLOYMENT INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL)			
ADDRESS			
CITY	STATE	ZIP CODE	HOME PHONE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	☐ M ☐ F
DEPARTMENT		
DIVISION/SCHOOL		
POSITION TITLE(S)		

SECTION II –BENEFICIARY INFORMATION

Primary Beneficiary Information *(Person to whom you wish to leave your money in case of your death.)*

NAME (LAST, FIRST, MIDDLE INITIAL)	RELATIONSHIP	SOCIAL SECURITY #	
ADDRESS	CITY	STATE	ZIP CODE

Contingency Beneficiary Information *(Person to whom you wish to leave your money in case of your death if Primary dies.)*

NAME (LAST, FIRST, MIDDLE INITIAL)	RELATIONSHIP	SOCIAL SECURITY #	
ADDRESS	CITY	STATE	ZIP CODE

SECTION III - OTHER EMPLOYMENT INFORMATION

1) Are you employed in any other job(s) with the Employer listed above? ☐ Yes ☐ No
If YES, with what department(s)?_____
a) Do these other job(s) provide you membership in the State Employees' Retirement System (ERS)? ☐ Yes ☐ No

2) Are you an ERS retiree collecting monthly retirement benefits or ERS member who is eligible to retire under ERS guidelines without early retirement penalties? ☐ Yes ☐ No

IMPORTANT: *If you answer YES to Questions #1a or #2 above, be sure to notify your employer immediately to prevent problems with payroll deductions related to the PTS Deferred Compensation Retirement Plan.*

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SECTION IV - SIGNATURE *(Certification Section)*

I certify that the above information is accurate. I understand that any incomplete/inaccurate information may result in back taxes and/or penalties imposed by the Internal Revenue Code. A copy of the PTS Deferred Compensation Retirement Plan Employee Information Booklet has been given to me. I understand that I will not contribute to Social Security, but will contribute to Medicare. I understand that 7.5% of my gross wages shall be deducted from each paycheck and deposited into the PTS Deferred Compensation Retirement Plan.

_____ _____

EMPLOYEE'S NAME *(Please print)* DATE

_____

EMPLOYEE'S SIGNATURE

The Plan Booklet can be made available to individuals who have special needs or who need auxiliary aids for effective communication (i.e., large print or audiotape), as required by the Americans with Disabilities Act of 1990. For more information, please call CFP/LSW at 596-7006 (neighbor islands may call toll-free at 1-800-600-7167).