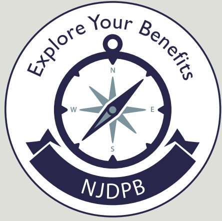
ABP-80-0069-1020



State of New Jersey • Department of the Treasury
DIVISION OF PENSIONS & BENEFITS — DEFINED BENEFIT & DEFINED CONTRIBUTION BUREAU
P.O. Box 295, Trenton, NJ 08625-0295

APPLICATION FOR TRANSFER / REHIRE —ALTERNATE BENEFIT PROGRAM (ABP) (REPORT OF TRANSFER)

This application must be completed by all ABP participants who are transferring employers and continuing their ABP participation.

PART ONE — MEMBER INFORMATION (To be completed by the member)

Name ____
First *Middle* *Last*

Address ____
Street *City* *State* *Zip Code*

ABP Membership Number______________________ Former Employer ______________________

Former Job Title______________________ Resignation Date ______/______/______

New Employer Name______________________________

Note: Any change you wish to make to beneficiaries or to payroll deductions must be made on the appropriate change forms which may be obtained from your benefits officer. If you had a Salary Reduction Agreement with your former employer and wish to continue the reduction, you must sign a new agreement with your new employer.

PART TWO — EMPLOYER CERTIFICATION (To be completed by the employer)

Employee's Title____

Appointment Date______/______/______ Carrier ______________________

Full-Time Employee ☐ Yes ☐ No Employed ☐ 10 Months ☐ 12 Months

Academic ☐ Yes ☐ No Social Security Number (last four digits) ______________

Annual Base Salary $ ______________ Location or Payroll Number ______________________

I certify that this employee and position meets the eligibility criteria for the retirement system as provided by law. I acknowledge that I am subject to penalty for falsifying or permitting to be falsified any record, application, form, or report of the retirement system in an attempt to defraud the system pursuant to N.J.S.A. 43:3C-15. Two signatures required.

______________________ ______________________ ______/______/______
Print Certifying Officer Name *Signature* *Date*

______________________ ______________________ ______/______/______
Print Certifying Officer Supervisor Name *Signature* *Date*

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Institution