ENROLLMENT FORM

WASHINGTON STATE Department of Retirement Systems

P.O. Box 48380 Olympia, WA 98504-8380 ◆ www.drs.wa.gov
Toll Free: 1.800.547.6657 ◆ Olympia Area: 360.664.7000 ◆ TTY: 360.586.5450

Clear Form

INSTRUCTIONS

Complete this form if you are a new member of or a returning member to a LEOFF or WSPRS eligible position. All plan members must complete a "Beneficiary Designation" form. **Return completed form to your employer.**

PERSONAL DATA - To be completed by member and returned to employer

Name (Last, First, Middle)	Maiden Name	Social Security Number

Mailing Address	City	State	ZIP

Phone	Alternate Phone	Email Address

I certify all of the information I have entered on this form is true and complete.

Employee Signature	Date

EMPLOYER DATA - To be completed by employer and returned to DRS

Reporting Group	First Date of Employee Eligibility	Retirement System (check one)	Plan
	M M D D Y Y Y Y	☐ WSPRS ☐ LEOFF	☐ Plan 1 ☐ Plan 2

Employee Position Title

Print or type employer name and mailing address below:

I certify all of the information entered on this form is true and complete and the employee's Social Security number has been verified.

Print Name	
Personnel or Payroll Representative Title	Phone Number
Signature	

Department of Retirement Systems (DRS) requires that you provide your Social Security number for this form.

- DRS will use your Social Security number as a reference number and to ensure that any funds disbursed under your account are correctly reported to the IRS.
- DRS will not disclose your Social Security number unless required by law.
- Internal Revenue Code Sections 6041(a) and 6109 allow DRS to request your Social Security number.