Request for Service Credit Cost Information — Leave of Absence

888 CalPERS (or 888-225-7377) • TTY: (877) 249-7442

Name of Member (Last Name, First Name, Middle Initial) | Social Security Number or CalPERS ID

Section 1 About You

The earlier in your career you purchase service credit, the lower your cost will be.

Any balance resulting from an election must be paid in full by your retirement date.

Purchase early so you have enough time to pay the balance in full by your retirement date, or your retirement benefit will be reduced by the actuarial equivalent of your remaining balance.

Member Mailing Address

City | State | ZIP Code

( ) Daytime Phone | Email Address

Have you submitted a retirement application? ☐ No ☐ Yes ______ Retirement Date (mm/dd/yyyy)

Have you ever been a member of a public retirement system in California other than CalPERS?

☐ No ☐ Yes ______ Name of System(s)

If yes, have you purchased the service being requested in that retirement system? ☐ No ☐ Yes

Section 2 Leave of Absence Employment Information

Provide the name of the employer that granted the leave.

List the dates and select the type of leave for each period requested.

If you need more space to enter additional leaves of absence, please attach a separate sheet.

If you have established reciprocity or have an approved final compensation exchange, we will contact the retirement system to determine your highest pay rate, which can be used in the calculation of your Leave of Absence service credit.

Employer

Type of Leave (Select one that applies to the dates below):

☐ Maternity/Paternity ☐ Temporary Disability
☐ Educational ☐ Serious Illness*
☐ Sabbatical ☐ Service ______ Name of Non-Profit or Governmental Organization

Dates of Leave From (mm/dd/yyyy) | To (mm/dd/yyyy)

Type of Leave (Select one that applies to the dates below):

☐ Maternity/Paternity ☐ Temporary Disability
☐ Educational ☐ Serious Illness*
☐ Sabbatical ☐ Service ______ Name of Non-Profit or Governmental Organization

Dates of Leave From (mm/dd/yyyy) | To (mm/dd/yyyy)

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☐ Sabbatical ☐ Service ______ Name of Non-Profit or Governmental Organization

Dates of Leave From (mm/dd/yyyy) | To (mm/dd/yyyy)

* "Serious Illness" is an employer-approved leave of absence granted for the member's own serious illness or injury.

Put your name and Social Security number or CalPERS ID at the top of every page

Your Name ____________________ Social Security Number or CalPERS ID ____________________

Section 3 — Member Certification

Temporary Disability Leave: The employer must complete Section 4 and also route the form to the member's workers' compensation carrier to complete Sections 5 and 6.

I hereby certify under penalty of perjury the above information is true and correct to the best of my knowledge. I understand I must meet the requirements under California law. I have reviewed the publication ***A Guide to Your CalPERS Service Credit Purchase Options*** (PUB 12) and I meet all the requirements outlined in the publication. I understand it is my responsibility to ensure this form is received by CalPERS. I further understand any balance resulting from an election must be paid in full by my retirement date, or my retirement benefit will be reduced by the actuarial equivalent of the remaining balance.

Member Signature ____________________ Date (mm/dd/yyyy) ____________________

Next Step: For all types of leave, give the form to the employer that granted the leave to complete Section 4 of this request form.

Section 4 — Leave of Absence Employer Certification

Dates and type of leave in this section must be completed by the employer independently of what the member reports in Section 2.

Reminder: If the employee has indicated a retirement date in Section 1, it is imperative that CalPERS receive this completed Leave of Absence Employer Certification section promptly. Delays in receiving this information from your agency could affect the employee's ability to make their election prior to retirement.

Type of Leave (Select one that applies to the dates below):

- ☐ Maternity/Paternity
- ☐ Educational
- ☐ Sabbatical
- ☐ Temporary Disability
- ☐ Serious Illness*
- ☐ Service ____________________ Name of Non-Profit or Governmental Organization

Dates of Leave From (mm/dd/yyyy) ____________________ To (mm/dd/yyyy) ____________________

Type of Leave (Select one that applies to the dates below):

- ☐ Maternity/Paternity
- ☐ Educational
- ☐ Sabbatical
- ☐ Temporary Disability
- ☐ Serious Illness*
- ☐ Service ____________________ Name of Non-Profit or Governmental Organization

Dates of Leave From (mm/dd/yyyy) ____________________ To (mm/dd/yyyy) ____________________

Type of Leave (Select one that applies to the dates below):

- ☐ Maternity/Paternity
- ☐ Educational
- ☐ Sabbatical
- ☐ Temporary Disability
- ☐ Serious Illness*
- ☐ Service ____________________ Name of Non-Profit or Governmental Organization

Dates of Leave From (mm/dd/yyyy) ____________________ To (mm/dd/yyyy) ____________________

* "Serious Illness" is an employer-approved leave of absence granted for the member's own serious illness or injury.

Employer: Return the completed form to the member or, for temporary disability leave, forward it to the member's workers' compensation carrier (see Section 5).

I hereby certify that the above information is true and correct. I understand this provides CalPERS with the information required to assess eligibility, calculate the cost, and determine the amount of purchasable service credit. I understand there is employer liability associated with this service credit purchase.

Employer Signature ____________________ Title ____________________ Date (mm/dd/yyyy) ____________________

Printed Name ____________________ Daytime Phone ( ) ____________________ Fax ( ) ____________________

Put your name and Social Security number or CalPERS ID at the top of every page

Your Name | **Social Security Number or CalPERS ID**

Section 5

Temporary Disability Leave of Absence Certification

To be completed by the workers' compensation carrier that provides temporary disability benefits.

If the member had more than one temporary disability leave period, provide claim numbers and dates for each.

Workers' Compensation Carrier Information

Name of Employer's Disability Carrier

Carrier's Address

Employee's Claim Number | Beginning Date of Temporary Disability Payments (mm/dd/yyyy) | Ending Date of Payments (mm/dd/yyyy)

Effective Date of Permanent Disability Rating (mm/dd/yyyy)

Was there a settlement by Compromise and Release? ☐ No ☐ Yes If yes, you must provide a copy to CalPERS.

Section 6

Signature of Authorized Workers' Compensation Carrier Representative

Please return this request form to the member.

I hereby certify that the above information is true and correct. I understand this form provides CalPERS with the information required to determine eligibility and calculate the applicable service credit cost(s).

Carrier Representative Signature | Date (mm/dd/yyyy)

Printed Name | Title

( ) Daytime Phone

Mail to: **CalPERS Member Account Management Division** • P.O. Box 4000, Sacramento, California 95812-4000

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the System. For questions about this notice, our Privacy Policy, or your rights, please write to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at 888 CalPERS (or 888-225-7377).