



**CITY OF ATLANTA POLICE (SWORN) PENSION FUND**  
**ENROLLMENT CARD • 1933 PENSION ACT AS AMENDED IN 2011**  
**EMPLOYEE CONTRIBUTES 8% TO DB PLAN COMPONENT & 3.75% TO DC PLAN COMPONENT**

<b>EMPLOYEE:</b>				
	Last Name	First Name	MI	Maiden Name
<b>ADDRESS:</b>				
	Street #.	City	State	Zip Code
<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Single	<input type="checkbox"/> Married	Date Married
				Employment Start Date
			<b>POLICE</b>	
		Date of Birth	Social Security #	Department

**S- SPOUSE, C - CHILD OR DP - DOMESTIC PARTNER (RELATIONSHIP – CHECK ONE)**

**PRIMARY BENEFICIARY – IF MORE THAN ONE PRIMARY BENEFICIARY IS NAMED, MONTHLY PENSION BENEFITS WILL BE EQUALLY DIVIDED AMONG THOSE NAMED.**

<input type="checkbox"/> S			
<input type="checkbox"/> C			
<input type="checkbox"/> DP	Full Name	Social Security #	Date of Birth

<input type="checkbox"/> S			
<input type="checkbox"/> C			
<input type="checkbox"/> DP	Full Name	Social Security #	Date of Birth

<input type="checkbox"/> S			
<input type="checkbox"/> C			
<input type="checkbox"/> DP	Full Name	Social Security #	Date of Birth

<input type="checkbox"/> S			
<input type="checkbox"/> C			
<input type="checkbox"/> DP	Full Name	Social Security #	Date of Birth

**SECONDARY BENEFICIARY – IF YOUR PRIMARY BENEFICIARIES DIE OR BECOME INELIGIBLE, MONTHLY PENSION BENEFITS WILL BE EQUALLY DIVIDED AMONG ANY ELIGIBLE SECONDARY BENEFICIARIES NAMED.**

<input type="checkbox"/> S			
<input type="checkbox"/> C			
<input type="checkbox"/> DP	Full Name	Social Security #	Date of Birth

<input type="checkbox"/> S			
<input type="checkbox"/> C			
<input type="checkbox"/> DP	Full Name	Social Security #	Date of Birth

<input type="checkbox"/> S			
<input type="checkbox"/> C			
<input type="checkbox"/> DP	Full Name	Social Security #	Date of Birth

**REFUND DESIGNEE – A REFUND OF YOUR CONTRIBUTIONS, LESS ANY BENEFITS PAID, WILL BE MADE TO WHOMEVER YOU NAME AS A REFUND DESIGNEE IF:**  
**(1) YOU DO NOT HAVE A SPOUSE/MINOR CHILD OR DOMESTIC PARTNER AT THE TIME OF YOUR DEATH OR (2) YOUR BENEFICIARIES ARE NOT ELIGIBLE TO RECEIVE A MONTHLY PENSION BENEFIT UPON YOUR DEATH**

\_\_\_\_\_  
Name of Refund Designee

\_\_\_\_\_  
Social Security #

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date