

**CITY OF NEW ORLEANS  
EMPLOYEES' RETIREMENT SYSTEM  
1300 PERDIDO STREET, ROOM 1E12  
NEW ORLEANS, LA 70112 (504)  
658-1850 FAX (504) 658-1602**

**ACCUMULATED CONTRIBUTIONS AT TERMINATION OF SERVICE**

**NOTE: (It will take 60 - 90 to process your refund and/or rollover)**

INSTRUCTIONS: PRINT IN INK OR TYPE ALL ENTRIES EXCEPT SIGNATURE

**SECTION I - MUST BE COMPLETED BY APPLICANT**

NAME: \_\_\_\_\_  
(PLEASE PRINT)

STREET: \_\_\_\_\_  
CITY STATE ZIP

DAYTIME TELEPHONE #: ( ) \_\_\_\_\_ SSN \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**SECTION II - FUNDS LEFT ON DEPOSIT BY MEMBER - PLEASE CHECK ONE**

- \_\_\_\_\_ I elect to have my contributions remain on deposit pending further instruction from me. I understand that I have less than five (5) years of service and will accrue interest up to a maximum period of five (5) years.
- \_\_\_\_\_ I have at least five (5) but less than ten (10) years of service and I elect to leave my contributions on deposit and become eligible to receive a separation retirement allowance when I reach age 65.
- \_\_\_\_\_ I have at least ten (10) years of service and I elect to leave my contributions on deposit and become eligible to receive a separation retirement allowance when I reach age 60.

**SECTION III - CONVERSION OF SICK AND ANNUAL LEAVE - PLEASE CHECK ONE**

- \_\_\_\_\_ I have less than five (5) years of service credit and elect to convert my accumulated leave to additional retirement credit to obtain separation retirement eligibility.  
Number of Sick Leave Hours \_\_\_\_\_ Number of Annual Leave Hours \_\_\_\_\_
- \_\_\_\_\_ I qualify for a Separation Retirement and elect to convert my accumulated leave to obtain additional retirement credit.  
Number of Sick Leave Hours \_\_\_\_\_ Number of Annual Leave Hours \_\_\_\_\_
- \_\_\_\_\_ I do not want to convert any accumulated leave to retirement credit.

**SECTION IV - REFUND OR TRANSFER OF CONTRIBUTIONS - PLEASE CHECK ONE**

- \_\_\_\_\_ I request that NOMERS refund the total amount of my contributions and any interest directly to me. I am aware of the **MANDATORY 20% WITHHOLDING**.
- \_\_\_\_\_ I request a rollover of the total amount of my contributions and interest to the U.S. financial institution listed below. I understand that the named financial institution must provide an acceptance letter to NOMERS.
- \_\_\_\_\_ I request to have my contributions transferred to the public retirement system in the State Louisiana which is listed below.

\_\_\_\_\_  
Name of Institution/Pension Fund

\_\_\_\_\_  
Type of Plan (IRA, Qualified Trust)

Member Signature \_\_\_\_\_ Date \_\_\_\_\_

**NOTE: (It will take 60 - 90 to process your refund and/or rollover)**

**MUST BE COMPLETED BY DEPARTMENT OR AGENCY – AUTHORIZED REPRESENTATIVE**

- ( ) I CERTIFY THAT THIS MEMBER HAS TERMINATED EMPLOYMENT. DATE TERMINATED \_\_\_\_\_
- ( ) I CERIFY THAT THIS MEMBER HAS OR HAS NOT BEEN TERMINATED OR RESIGNED DUE TO HEALTH CONDITIONS.

\_\_\_\_\_  
PRINT NAME/TITLE

\_\_\_\_\_  
SIGNATURE

**FUNDS LEFT ON DEPOSIT**

- 1. Terminated members whose contributions remain on deposit with NOMERS may be eligible for a Separation Retirement.
- 2. **MINIMUM QUALIFICATIONS FOR A SEPARATION RETIREMENT**
  - a. A member of this system with five (5) years of service is eligible for a Separation Retirement Benefit at age 65.
  - b. A member of this system with ten (10) years of service is eligible for a Separation Retirement Benefit at age 60 with a 3% reduction for each year under age 62.
- 3. Terminated members who do not qualify for a Separation Retirement are permitted by Ordinance to leave his/her accumulated contributions on deposit for a period of five (5) years. Members' contributions will be credited with interest for the five year period.
- 4. If you wish to receive a Separation Retirement or have contributions remain on deposit for five (5) years with interest, please complete Section I, II and III.
- 5. Please keep your address and beneficiary(ies) up-to-date with this office.

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**REFUND OF CONTRIBUTIONS**

Members may obtain a refund of employee contributions and interest by completing Section I and IV.

Under certain circumstances an employee may obtain credit for service time related to previous refund(s) by repayment of the refund(s) plus interest.

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**TRANSFER OF FUNDS TO NEW ORLEANS SEWERAGE & WATER BOARD OR ANOTHER PUBLIC RETIREMENT SYSTEM IN THE STATE OF LOUISIANA**

Members must complete Section I and IV to request a transfer of funds and creditable service time to the New Orleans Sewerage & Water Board or another Public Retirement System in the State of Louisiana.

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**ROLLOVER OF FUNDS**

Members must complete Section I and IV in order to have funds rolled over to an IRA or Qualified Trust. An acceptance letter must be received from the Financial Institution acknowledging the rollover of funds will be accepted.

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**WAIVER OF PENSION AND ANNUITY RIGHTS**

Members requesting a REFUND, TRANSFER or ROLLOVER, are REQUIRED to ALSO complete a *RS-16 – Waiver of Pension and Annuity Rights* form.

**PLEASE BE MINDFUL THAT IT MAY TAKE 60 TO 90 DAYS BEFORE PROCESSING OF YOUR REQUEST IS COMPLETED.**

**EMPLOYEES' RETIREMENT SYSTEM  
OF THE CITY OF NEW ORLEANS  
1300 PERDIDO STREET, ROOM 1E12  
NEW ORLEANS, LA 70112**

**WAIVER OF PENSION AND ANNUITY RIGHTS**

I request a distribution of my accumulated contributions from the Employees' Retirement System of the City of New Orleans. I release and relieve the City of New Orleans, and the Board of Trustees of the Employees' Retirement System of the City of New Orleans of any and all obligations whatsoever for any pension or annuity which I may have earned or which may be due to me, my heirs or designee(s).

I understand that by withdrawing my accumulated contributions and interest, I will forfeit any right which I have or may have to a pension or annuity from the Employees' Retirement of the City of New Orleans.

I further understand that as of January 1, 1994, the City of New Orleans Retirement System is required to withhold 20% of my taxable amount (interest and contributions made after 01/01/94) or allow me to rollover the taxable amount into an IRA or Mutual Trust Fund.

NAME \_\_\_\_\_  
(PRINT)

SIGNATURE \_\_\_\_\_

ADDRESS \_\_\_\_\_  
(STREET NUMBER)

\_\_\_\_\_  
(CITY) (STATE) (ZIP)

SOCIAL SECURITY # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ DATE \_\_\_\_\_

**THIS FORM MUST BE WITNESSED BY TWO (2) PERSONS.**

**WITNESS 1**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_  
(CITY) (STATE) (ZIP)

**WITNESS 2**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_  
(CITY) (STATE) (ZIP)

**DIRECT DEPOSIT SIGN-UP FORM**

MONTHLY BENEFIT ( )  
 ANNUITY ( )

MEMBER # \_\_\_\_\_

PAYEE MUST KEEP THE EMPLOYEES' RETIREMENT SYSTEM INFORMED OF ANY ADDRESS CHANGES IN ORDER TO RECEIVE IMPORTANT INFORMATION ABOUT BENEFITS AND TO REMAIN QUALIFIED FOR PAYMENT.

THE AGREEMENT REPRESENTED BY THIS AUTHORIZATION REMAINS IN EFFECT UNTIL CANCELED BY THE PAYEE BY WRITTEN NOTICE TO THE RETIREMENT OFFICE, OR BY DEATH OR LEGAL INCAPACITY OF THE PAYEE. UPON CANCELLATION, THE PAYEE SHOULD NOTIFY THE RECEIVING FINANCIAL INSTITUTION THAT HE/SHE IS DOING SO.

**ATTACH VOIDED CHECK HERE**  
 (IF CHECKING ACCOUNT)

**(TO BE COMPLETED BY PAYEE)**  
**SECTION 1**

A. NAME (LAST, FIRST, MIDDLE INITIAL)	SOCIAL SECURITY NUMBER OF PAYEE
B. MAILING ADDRESS <span style="float: right;">IS THIS A NEW ADDRESS? YES ___ NO ___</span>	TELEPHONE NUMBER OF PAYEE
C. CITY <span style="margin-left: 100px;">STATE</span> <span style="float: right;">ZIP CODE</span>	TYPE OF ACCOUNT: CHECKING ___ SAVINGS ___
ACCOUNT NO. _____	<b>IF JOINT ACCOUNT:</b> NAME OF OTHER JOINT ACCOUNT HOLDER; PHONE NO.
<p style="text-align: center;">PAYEE CERTIFICATION</p> I CERTIFY THAT I AM ENTITLED TO THE PAYMENT IDENTIFIED ABOVE. IN SIGNING THIS FORM, I AUTHORIZE MY RETIREMENT CHECK TO BE SENT TO THE FINANCIAL INSTITUTION NAMED BELOW TO BE DEPOSITED TO THE DESIGNATED ACCOUNT.	ADDRESS OF OTHER JOINT ACCOUNT HOLDER
SIGNATURE OF PAYEE <span style="float: right;">DATE</span>	
<b>X</b>	

**(TO BE COMPLETED BY FINANCIAL INSTITUTION)** **SECTION 2**

NAME AND ADDRESS OF FINANCIAL INSTITUTION	TYPE OF ACCOUNT: CHECKING ___ SAVINGS ___
	ROUTING NO. _____
	ACCOUNT NO. _____
	NAMES ON ACCOUNT _____
	(MUST BE PAYEE; JOINT ACCOUNT ACCEPTABLE)
<p style="text-align: center;">FINANCIAL INSTITUTION CERTIFICATION</p> I CONFIRM THE IDENTITY OF THE ABOVE-NAMED PAYEE AND THE ACCOUNT NO. AND OWNER. AS REPRESENTATIVE OF THE ABOVE NAMED FINANCIAL INSTITUTION, I CERTIFY THAT THE FINANCIAL INSTITUTION AGREES TO RECEIVE AND DEPOSIT THE PAYMENT DESCRIBED ABOVE.	
PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE
	TELEPHONE # <span style="float: right;">DATE</span>

PLEASE BRING OR MAIL THIS DOCUMENT TO:

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 NEW ORLEANS, LA 70112  
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