



STATE OF HAWAII  
PTS DEFERRED COMPENSATION RETIREMENT PLAN  
for Part-Time, Temporary, and Seasonal/Casual Employees of the State

**ENROLLMENT FORM**

Please type or print in ink. Complete ALL information. Failure to complete and return this form may delay or prevent receiving your distribution check after you separate from service.

**Send your completed form to:**  
National Benefits Services, LLC, P.O. Box 698, West Jordan, UT 84084

**SECTION I - IDENTIFYING/EMPLOYMENT INFORMATION**

NAME (LAST, FIRST, MIDDLE INITIAL)				SOCIAL SECURITY NUMBER		DATE OF BIRTH		<input type="checkbox"/> M	
ADDRESS				DEPARTMENT					
CITY		STATE HI	ZIP	DIVISION/SCHOOL					
HOME PHONE				POSITION TITLE(S)					

**SECTION II - BENEFICIARY INFORMATION** (List person to whom you wish to leave your money in case of your death.)

NAME (LAST, FIRST, MIDDLE INITIAL)			RELATIONSHIP		SOCIAL SECURITY#		
ADDRESS			CITY		STATE		ZIP

**SECTION III - OTHER EMPLOYMENT INFORMATION**

1) Are you employed in any other State job(s)? If YES, with what department(s)? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
a) Do these other job(s) provide you membership in the State Employees' Retirement System (ERS)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2) Are you an ERS retiree collecting monthly retirement benefits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>IMPORTANT:</b> If you answer YES to Questions #1a or #2 above, be sure to notify your employer immediately to prevent problems with payroll deductions related to the PTS Deferred Compensation Retirement Plan.		

The Plan Booklet can be made available to individuals who have special needs or who need auxiliary aids for effective communication (i.e., large print or audiotape), as required by the Americans with Disabilities Act of 1990. For more information, please call CFP/LSW at 596-7006 (neighbor islands may call toll-free at 1-800-600-7167).

**SECTION IV - SIGNATURE (Certification Section)**

I certify that the above information is accurate. I understand that any incomplete/inaccurate information may result in back taxes and/or penalties imposed by the Internal Revenue Code. A copy of the PTS Deferred Compensation Retirement Plan Employee Information Booklet has been given to me. I understand that I will not contribute to Social Security, but will contribute to Medicare. I understand that 7.5% of my gross wages shall be deducted from each paycheck and deposited into the PTS Deferred Compensation Retirement Plan.

EMPLOYEE'S SIGNATURE	DATE
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