

**MEMBERSHIP
ENROLLMENT AFFIDAVIT**

348 W. Hospitality Lane, 3rd Floor
San Bernardino, CA 92415-0014
www.SBCERA.org
(909) 885-7980

(For new hire employee or newly appointed to regular full time position)

NUMBERS 1 THROUGH 16 TO BE COMPLETED BY EMPLOYEE. PLEASE PRINT.

1. Last Name		2. First Name		3. Middle Name	
4. Social Security Number		5. Email Address		6. Home Telephone	
7. Mailing Address			City	State	Zip Code
8. Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	9. Date of Birth		10. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner		
11. Date of Marriage		12. Spouse/Domestic Partner Name			
13. Have you previously been employed with the County or any other public agency in California? <input type="checkbox"/> Yes* <input type="checkbox"/> No *Name of Public Agency:					
14. Do you wish to establish reciprocity? <input type="checkbox"/> Yes <input type="checkbox"/> No					
15. For employees who are age 60 or older at the time of appointment to a regular position: <input type="checkbox"/> I hereby declare that I am 60 years of age at time of appointment & choose to <u>waive</u> SBCERA membership. Initial () <input type="checkbox"/> I hereby declare that I am 60 years of age at time of appointment & choose to <u>join</u> SBCERA. Initial () Note: If you choose to waive membership, you must do so within 90 days following initial appointment to a regular position.					
16. Beneficiary Designation (Select only 1 box; appointing a Trust Account as beneficiary is not valid): <input type="checkbox"/> I designate my estate. <input type="checkbox"/> I wish to designate multiple beneficiaries. I have completed and attached a Beneficiary Designation/Change Form. <input type="checkbox"/> I designate the following person as my beneficiary under the terms of the County Employees' Retirement Act of 1937:					
Last Name		First Name		Middle Name	
				Beneficiary SSN	
				Date of Birth	
				Relationship	
Under penalty of perjury, I declare the foregoing statements are true and current to the best of my knowledge and belief.					
Employee Signature			Date		
Notification Of Spouse/Domestic Partner					
Government Code section §31760.3 requires the current spouse/domestic partner be notified of the selection or change of beneficiary made by a member. If there is no signature below or if you are not married, a Justification For Non-Signature of Spouse/Domestic Partner Form must be returned to SBCERA along with the Membership Enrollment Affidavit.					
Spouse/Domestic Partner Signature				Date	

TO BE COMPLETED BY HIRING EMPLOYER/DEPARTMENT

Membership Plan:		Date Appointed to Regular Position:		Employer:	
<input type="checkbox"/> General <input type="checkbox"/> Safety				<input type="checkbox"/> County of San Bernardino <input type="checkbox"/> If other, please specify:	
FOR COUNTY OF SAN BERNARDINO USE ONLY:					
Please specify the Hiring Department:					
Payroll /Human Resources Dept. Representative (Print Name)				Telephone	
FOR SCAQMD USE ONLY: <input type="checkbox"/> OCM <input type="checkbox"/> Non-OCM <input type="checkbox"/> Pre 79 <input type="checkbox"/> Post 79 <input type="checkbox"/> Not eligible for Employer Pick-Up (Additional Current)					