Please Type or Print in Ink

EE#: _____
LOPFI Use Only

ARKANSAS LOCAL POLICE AND FIRE RETIREMENT SYSTEM (LOPFI)
Membership Application

Employer

_____ Paid: ☐ Enrollment Date: _____
City/Dept Name Volunteer: ☐

Member

Name: _____
Last Name First Name Middle Initial

Social Security Number: _____ Birth Date: _____ Male: ☐ Female: ☐

Home Address: _____
Street City State Zip Code

Beneficiaries

NOMINATION OF BENEFICIARY: I hereby direct LOPFI to pay my accumulated member contributions or the benefit which may be payable in the event of my death before retirement to:

My _____ , _____ _____
(Relationship to Applicant) (Print Full Name of Primary Beneficiary) Social Security Number

Birth Date: _____ Male: ☐ Female: ☐ Address: _____
Street City State Zip Code

OTHERWISE TO:

My _____ , _____ _____
(Relationship to Applicant) (Print Full Name of Contingent Beneficiary) Social Security Number

Birth Date: _____ Male: ☐ Female: ☐ Address: _____
Street City State Zip Code

If you wish to nominate more than one contingent beneficiary, to share equally in your accumulated member contributions in the event of your death, please list additional name(s) and address(es) on the back of this form.

I DO HEREBY AUTHORIZE MY EMPLOYER TO MAKE ANY NECESSARY PAYROLL DEDUCTIONS FROM MY SALARY AS AUTHORIZED BY A.C.A 24-10-101, ET. SEQ., AS AMENDED, AND DECLARE THE ABOVE STATEMENTS TO BE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. THIS APPLICATION MUST BE SIGNED BY THE APPLICANT AND EMPLOYER REPRESENTATIVE.

_____ _____
Signature of Employer Representative DATE Signature of Member DATE

Please mail original copy to:
LOPFI
620 W. 3rd, Suite 200
Little Rock, Arkansas 72201-2223

Form DC118 Revised 01-2009