

TO: DEFINED CONTRIBUTION RETIREMENT PROGRAM (DCRP)
NJ DIVISION OF PENSIONS AND BENEFITS
PO BOX 295, TRENTON, NJ 08625-0295

FROM: _____
EMPLOYER NAME LOCATION ID

SUBJECT: DCRP ELIGIBILITY STATUS CHANGE VERIFICATION FORM

This is to advise you that:

NAME _____

MAILING ADDRESS _____

MEMBERSHIP NO. _____
ASSIGNED BY DIVISION OF PENSIONS AND BENEFITS

SOCIAL SECURITY NO. _____

ANNUAL SALARY \$ _____

Has ceased contributing to the DCRP because of:

1) **LOSS OF ELIGIBILITY** — No longer eligible for DCRP due to annual salary that is less than the required minimum.
Effective date _____

2) **STATUS CHANGED TO FULL TIME** — Eligible for enrollment in the Public Employees' Retirement System, Teachers' Pension and Annuity Fund, Police and Firemen's Retirement System, or State Police Retirement System.
Effective date _____

3) **TERMINATION OF EMPLOYMENT** —
Effective date _____
Reason for termination _____

4) **LEAVE OF ABSENCE** —
Granted without pay effective _____ through _____
for _____

Has resumed contributing to the DCRP because of:

5) **RETURN FROM LEAVE OF ABSENCE** —
Effective date _____

SIGNATURE OF CERTIFYING OFFICER