

REQUIRED

Member Number: E or G

Last 4 Digits
of SSN

Employee
Identification Number



Board of Education
Retirement System

MAILING ADDRESS | 65 COURT STREET, 16TH FL.
BROOKLYN, NEW YORK 11201-4965

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You may submit this form via fax to (718) 935-4124 or (718) 935-3830.

Prefix

Mr Mrs Ms Miss Other _____

Name

M.I.

Last Name

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Home/Legal Address

Apt. No.

--	--

City

State

Zip Code

--	--	--

Mailing Address (if different from above)

Apt. No.

--	--

City

State

Zip Code

--	--	--

Primary Telephone Number

Secondary Telephone Number

	Is this a Cell # <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this a Cell # <input type="checkbox"/> Yes <input type="checkbox"/> No
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REQUIRED - Primary Email Address

Secondary Email Address

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OFFICIAL DATE OF RECEIPT

LOST CHECK AFFIDAVIT



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ACKNOWLEDGEMENT

I, being duly sworn, depose and say that I reside at the above address, am the member/retiree/beneficiary entitled to a benefit from the Board of Education Retirement System of the City of New York, and did not receive the payment dated:

Is this a Check discovered via BERS website?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Date of Lost Check	Amount of Check	Check Number	Type of Check
MM / DD / YYYY	\$		If unknown, please leave this section blank.

Date of Lost Check	Amount of Check	Check Number	Type of Check
MM / DD / YYYY	\$		If unknown, please leave this section blank.

Date of Lost Check	Amount of Check	Check Number	Type of Check
MM / DD / YYYY	\$		If unknown, please leave this section blank.

Therefore, I make this affidavit to induce the issuance of a duplicate check in the above said amount.

In the event the said original missing check comes into my hands at any time, I promise to return it immediately to the Division of Pensions, Office of the Comptroller of the City of New York. If at any time it is found that said original check has been cashed by me, I hereby authorize the New York City Office of the Comptroller to deduct the amount of said check from any future payments due me.

I understand that any person who presents false or fraudulent information in an application with intent to defraud BERS is guilty of a crime and may be subject to fines and confinement in prison.

DO NOT SIGN OR DATE UNLESS IN FRONT OF A NOTARY

Signature _____ **Date** _____
REQUIRED

State of _____ County of _____

On this _____ day of _____ in the year 20 _____

personally appeared before me the said _____

to me known to be the individual described in and who executed the foregoing document, and he (she) duly acknowledged to me that he (she) executed the same, and the statements contained therein are true.

Signature of Notary Public or Commissioner of Deeds

Affix official seal in the box below



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BERS | Board of Education
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LOST CHECK AFFIDAVIT

THE SECTION BELOW SHOULD ONLY BE COMPLETED FOR LOST ROLLOVER CHECKS

I elect to have my lost rollover check/checks sent to the institution specified below:

AUTHORIZATION FOR TRUSTEE-TO-TRUSTEE TRANSFER
UNDER THE UNEMPLOYMENT COMPENSATION AMENDMENT ("UCA")

RELIANCE ON REPRESENTATION

I hereby designate the below named financial institution as transferee of my Eligible Rollover Distribution ("ERD") (as trustee of my individual retirement account or individual retirement annuity), or qualified plan or annuity. To my best belief and understanding, I represent that the designated transferee is in fact an Eligible Retirement Plan ("ERP") and is an IRA or a Qualified Trust or Annuity, and that it will accept the direct transfer for my benefit.

IMPORTANT: PLEASE RECORD THE EXACT NAME AND ADDRESS OF THE ERP INSTITUTION
AS YOU WISH IT TO APPEAR ON THE CHECK:

Account Holder Name

IRA Account Number

Name of Institution

Mailing Address (Street)

City

State

Zip Code

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Type of Transfer

Rollover IRA Qualified Trust Annuity

Your Initials

REQUIRED _____

