



# APPLICATION TO START OR STOP PAYMENT OF RETIREMENT BENEFITS TO A REVOCABLE TRUST

State Form 50928 (R3 / 5-12)

## INDIANA PUBLIC RETIREMENT SYSTEM PUBLIC EMPLOYEES' RETIREMENT FUND

1 North Capitol Avenue, Suite 001  
Indianapolis, IN 46204-2014  
Telephone: (888) 526-1687 (Toll-free)  
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Web site: [www.inprs.in.gov](http://www.inprs.in.gov)

\* This agency is requesting disclosure of Social Security Numbers in accordance with Internal Revenue Code 3405; disclosure is mandatory and this form cannot be processed without it.

*Indiana Code 5-10.2-4-7(d) allows a member to direct their monthly benefit payment to a Revocable Trust. In order to qualify, the trust must permit unrestricted / unconditional access to amounts held in the trust and must be revocable at any time. Members may make this election at the time they retire or at any time thereafter.*

### To Start Payments

*If you wish to begin directing your benefit payments to an eligible Revocable Trust, you should complete the Member Information section on this page and Part A of this form. Part B may be discarded. Submit an Authorization for Deposit of Recurring Payment (State Form 39175) with this application. Direct deposit is the preferred method to disperse monthly benefit payments.*

**IMPORTANT:** *You should consult with your tax advisor before completing this form. You may need to obtain a Taxpayer Identification Number other than your Social Security Number for the revocable trust.*

### To Stop Payments

*If you wish to stop further payments to a Revocable Trust you should complete the Member Information section on this page and Part B of this form. Part A can be discarded.*

*Please return the completed form to PERF at the above address.*

MEMBER INFORMATION	
Name of member <i>(last, first, middle initial)</i>	Social Security Number *
Address <i>(number and street, city, state, and ZIP code)</i>	
Home telephone number (       )	Other telephone number (       )
E-mail address	

**APPLICATION TO START OR STOP PAYMENT OF RETIREMENT BENEFITS  
TO A REVOCABLE TRUST (continued)**

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Name of member ( <i>last, first, middle initial</i> )	Social Security Number *
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**PART A: REVOCABLE TRUST AUTHORIZATION & AFFIDAVIT**  
*Complete this section only if you wish your monthly benefit paid to a revocable trust.*

I hereby certify that I have requested the Indiana Public Employees' Retirement Fund pay my monthly retirement benefit to my Revocable Trust identified as:

\_\_\_\_\_ , \_\_\_\_\_  
*Print name of trust* *Social Security Number\* or taxpayer identification number*

I further certify that the before stated trust complies with terms set forth in Indiana Code section 5-10.2-4-7(d). I can revoke the trust at any time and I have unconditional access to trust funds.

I acknowledge and agree that the payee designation will be in *my name* Revocable Trust.

I further acknowledge and agree that, should there be a change in the terms or conditions of the trust instrument that would conflict with the provisions of IC 5-10.2-4-7(d), I will immediately notify the Fund and cooperate with the Fund to ensure that retirement benefit distributions are made in compliance with law.

I also hereby agree and acknowledge that the terms of this instrument shall be binding upon my heirs, executors, administrators and assigns and I will hold the Fund harmless for any and all damages suffered as a result of any misrepresentation made in this instrument or by any act or omission with regard to the terms or administration of the trust.

I also hereby acknowledge that I understand the terms of this affidavit and any ambiguities herein are to be resolved in favor of the Indiana Public Employees' Retirement Fund. I hereby acknowledge that I have had ample time and opportunity to secure legal counsel for the purpose of explaining any of these declarations contained within. I affirm, under the penalties for perjury, that the foregoing representations are true.

Signature of member	Date ( <i>month, day, year</i> )
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Printed name of member
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STATE OF \_\_\_\_\_ SS:  
COUNTY OF \_\_\_\_\_

Subscribed and sworn to before me, a notary public, in and for the state and county above named,  
by the said member, \_\_\_\_\_  
on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

SEAL

Signature of notary public	Printed name of notary public
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County of residence	State of residence	Date commission expires ( <i>month, day, year</i> )
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**APPLICATION TO START OR STOP PAYMENT OF RETIREMENT BENEFITS  
TO A REVOCABLE TRUST (continued)**

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Name of member <i>(last, first, middle initial)</i>	Social Security Number *
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**PART B: REVOCABLE TRUST STOP PAYMENT AFFIDAVIT**  
*Complete this section only if you wish to stop payment to a revocable trust.*

Effective with the receipt to this notice I hereby authorize and direct the Public Employees' Retirement Fund to stop payment of my monthly benefit to my Revocable Trust. I understand that it is my responsibility to submit this form in a timely fashion and that failure to do so will absolve the Fund from any responsibility for payments that may be misdirected.

Signature of member	Date <i>(month, day, year)</i>
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Printed name of member
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STATE OF \_\_\_\_\_  
COUNTY OF \_\_\_\_\_

SS:

Subscribed and sworn to before me, a notary public, in and for the state and county above named,  
by the said member, \_\_\_\_\_  
on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

SEAL

Signature of notary public	Printed name of notary public
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County of residence	State of residence	Date commission expires <i>(month, day, year)</i>
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