



## APPLICATION FOR REFUND OF CONTRIBUTIONS - GDCP

1. Please print or type clearly.
2. Send this form to your Payroll Department. **Do not send to Georgia Defined Contribution Plan (GDCP).**
3. If the taxable portion (interest earned) of your refund is *less* than \$200.00, GDCP will withhold federal income tax. Typically the rate is 30%, or if you are over 59 1/2, the withholding rate is 20%.
4. If the taxable portion (interest earned) of your refund is *more* than \$200.00, GDCP is required to withhold federal income tax unless you directly roll over the taxable portion to another eligible retirement plan. You will be notified by GDCP if this applies to you.
5. Refunds include accumulated employee contributions and credited interest earnings (if any).
6. **Upon receipt of refund application in this office, please allow 8 weeks for processing.**

### SECTION 1 - MEMBER INFORMATION

Name: \_\_\_\_\_ SSN:

(Last)                                      (First)                                      (MI)                                      (Maiden)

Mailing Address: \_\_\_\_\_

(Street)                                      (City)                                      (State)                                      (Zip Code)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ E-mail : \_\_\_\_\_ Daytime Phone No: (\_\_\_\_) \_\_\_\_\_

(mm)    (dd)    (yyyy)

State Agency/Department/School System/Unit of the Board of Regents in which you were employed: \_\_\_\_\_

### SECTION 2 - MEMBER SIGNATURE

**I understand that by receiving this refund I waive all rights to benefits accrued from this system.**

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### SECTION 3 - PERSONNEL/PAYROLL USE ONLY

**Please provide the following dates for the above mentioned employee (if applicable).**

Termination Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Payroll Deduction: \_\_\_\_/\_\_\_\_/\_\_\_\_

(mm)    (dd)    (yyyy)                                      (mm)    (dd)    (yyyy)

Salary: \$ \_\_\_\_\_ Contributions: \$ \_\_\_\_\_ for \_\_\_\_/\_\_\_\_

(mm)    (yyyy)

**I certify that this employee has terminated employment, and that the total salary and contributions listed above are for the month of termination.**

Payroll Officer Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(mm)    (dd)    (yyyy)

Agency #: \_\_\_\_\_

Telephone #: (\_\_\_\_) - \_\_\_\_\_ Email Address: \_\_\_\_\_