

Form 1100
Revised 06/12/2006
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RETIREMENT PLAN ENROLLMENT

State Budget and Control Board
South Carolina Retirement Systems

Attention: Enrollment
Box 11960, Columbia, SC 29211-1960

Print or type in black ink
and sign in blue ink.
Please read the
instructions on page 2
before completing this
form.

ACTION REQUESTED (Check One):

- ☐ NEW ENROLLEE (First-time membership)
☐ OPEN ENROLLMENT (Irrevocable election from State ORP)
☐ CHANGE OF EMPLOYER (Transfer)/DUAL EMPLOYMENT
☐ CHANGE OF INFORMATION
- ☐ Name (Prior Name): _____
(ATTACH LEGAL DOCUMENT INDICATING NAME CHANGE)
☐ Address _____
☐ SSN (Old Number): _____
☐ Date of Birth _____

SECTION I: EMPLOYEE INFORMATION (TO BE COMPLETED BY THE EMPLOYEE)

1. Last Name & Suffix		2. First/ Middle Name		3. Social Security Number (ATTACH A COPY OF YOUR SOCIAL SECURITY CARD.)	
4. Address		5. City		6. State	7. ZIP+4
8. Sex M=Male F=Female	9. Date of Birth	10. Telephone Number	11. Have you ever been a member of the South Carolina Retirement Systems? <input type="checkbox"/> No <input type="checkbox"/> Yes	12. If item 11 is "Yes", indicate the name(s) of your former employer: Did you withdraw your contributions? <input type="checkbox"/> No <input type="checkbox"/> Yes	
13. Do you currently have a pending refund request? <input type="checkbox"/> No <input type="checkbox"/> Yes			14. Are you now receiving or have you applied to receive a monthly benefit from any of the Retirement Systems' retirement plans? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Application in Process		
15. Retirement Plan Election (CHOOSE ONE) <input type="checkbox"/> SCRS <input type="checkbox"/> PORS (See instructions) <input type="checkbox"/> State ORP (If State ORP, please complete item 16.) <input type="checkbox"/> GARS - Senator (100.01) <input type="checkbox"/> GARS - Representative (100.02) <input type="checkbox"/> JSRS - Judge (001.00) <input type="checkbox"/> JSRS - Solicitor (002.00)				16. Select ORP Vendor <input type="checkbox"/> AIG Valic <input type="checkbox"/> MetLife <input type="checkbox"/> TIAA-CREF <input type="checkbox"/> The Hartford	

17. An employee hired by an eligible employer (school district, higher education, technical college, state department, agency, bureau, commission, and institution) covered under the South Carolina Retirement System (SCRS), may elect to participate in either the traditional defined benefit plan, SCRS, or the optional defined contribution plan, State ORP. The election to participate in State ORP must be made within 30 calendar days after entry into service (date of hire).

If I do not make an election within the required time, I will be considered to have elected membership in SCRS. Participants in the State ORP assume all investment risk. The election to participate in State ORP is irrevocable, except a State ORP participant may make a one-time irrevocable election to join SCRS during any open enrollment period after the first annual anniversary, but before the fifth annual anniversary of the initial enrollment in State ORP.

I understand that, unless a designated beneficiary is on file, my estate will be designated as my beneficiary until the Retirement Systems receives from me a properly executed beneficiary form.

My signature below indicates that my employer has explained the retirement plan options available to me and has provided me with access to information necessary to make an informed choice. My signature on this document confirms my retirement plan election as indicated in block 15 above.

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA RETIREMENT SYSTEMS. THE SOUTH CAROLINA RETIREMENT SYSTEMS RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

Employee's Signature _____ Date _____ Witness _____
(Required only when signed by mark)

SECTION II: EMPLOYER INFORMATION (TO BE COMPLETED BY THE EMPLOYER)

A COPY OF THE EMPLOYEE'S SOCIAL SECURITY CARD MUST BE ATTACHED TO THIS FORM TO ENROLL THE MEMBER. THE NAME ON THE SOCIAL SECURITY CARD MUST MATCH THE NAME LISTED IN ITEMS 1-2 IN SECTION I OF THIS FORM.

18. Employer Code	19. Employer Name	20. Please indicate if you are the employee's primary or secondary employer. (Annual member statements are sent to primary employers for distribution to members.) <input type="checkbox"/> Primary Employer <input type="checkbox"/> Secondary Employer	
21. Original Date of Hire with Employer listed in Items 18-19	22. Date of Membership	23. Employee's Position Title	24. Employee's Annual Salary
25. I hereby certify that the employee listed in Section I of this form is eligible for the retirement plan selected.			
Employer Signature _____		Date _____	Work Telephone Number _____
For more information, please contact Customer Services at (800) 868-9002 (in state only), (803) 737-6800, or cs@scrs.state.sc.us			