

**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

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

REQUIRED - Primary Email Address	Secondary Email Address

OFFICIAL DATE OF RECEIPT

<b>BERS USE ONLY</b>  _____ Processing Date
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# LOST CHECK AFFIDAVIT



<b>REQUIRED</b> 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**

### 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.  _____ <i>Signature of Notary Public or Commissioner of Deeds</i>	<b>Affix official seal in the box below</b> <div style="border: 1px solid black; height: 150px; width: 100%;"></div>
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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

Type of Transfer

Rollover IRA     Qualified Trust     Annuity

**Your Initials**

**REQUIRED** \_\_\_\_\_

