Commonwealth of Pennsylvania
PA Municipal Retirement Board
PMRB-5A Rev. 02/08

NOTIFICATION OF CHANGE

IMPORTANT: This form is to request PMRS to adjust the record of the following enrolled pension plan member. The information provided in this section should reflect the information currently recorded in PMRS files.

Employee/ Retiree Name: _____ MKEY (if known) or Last 4 Digits of SSN: _____ Effective Date of Adjustment: ____ / ____ / ____

Municipality Name: _____ Municipal Code Number: _____-_____-_____

Please check the box(es) below and indicate how the information for the member should now be recorded in PMRS files.

☐ 1. Corrected Name: _____

☐ 2. Address: Old: _____

New: _____

☐ 3. Social Security Number: _____

☐ 4. Date of Birth: Current: _____ Corrected: _____

☐ 5. Retiree's Return to Active Service: *("Effective Date of Adjustment" at top of page should be the Date of Return to Service)*

Note: Items 6, 7, and 8 may require additional processing and / or documentation and should not be considered "changed" until verification of change being requested of PMRS has been provided by PMRS to the plan's contact.

☐ 6. Request to Reinstate Previous Service (Return to Service):
Previous Start Date: ____ / ____ / ____ Previous End Date: ____ / ____ / ____

☐ 7. Certification of Service Not Previously Documented: *(Attach list of time to be credited and compensation paid by year.)*

☐ 8. Request to Purchase Service: Start Date: ____ / ____ / ____ End Date: ____ / ____ / ____
(If compensated by the plan's sponsor during the period of service to be purchased, attach a list of the compensation paid by year.)

Type of Service: Military (Attach copy of DD-214) _____ Service before plan's creation _____ Other _____

Explanation: _____

Change of Status

☐ 9. Begin Leave Without Pay (LWOP) Date: ____ / ____ / ____ ☐ 10. Return from LWOP Date: ____ / ____ / ____

☐ 11. LWOP Type: *(Please check one item below)* **NOTE: If individual's employment was terminated, please use PMRB-4 form.**

Maternity ____ Military: ____ Laid-off: ____ Short-term Disability: ____

Other (Please explain) _____

_____ ____ / ____ / ____
Signature of Member Date

_____ _____ ____ / ____ / ____
Signature of Certifying Plan Official Name of Certifying Plan Official *(Please Type or Print Legibly)* Date