



Special Power of Attorney (POA) for PERS

Section A: Applicant information (Type or print clearly in dark ink. Illegible forms could be returned to you, which could delay your request.)

First name		MI	Last name		Social Security number*
Mailing address (street or PO box)					PERS ID (optional)
City		State	Zip code	Country	Date of birth (mm-dd-yyyy)
Day phone number	Work phone number	Cell phone number		Personal email	

This document gives the person(s) you designate the power to make any and all decisions for PERS-related matters on your behalf. This Power of Attorney takes effect on the date signed and supersedes any other POA on file with PERS. It remains in effect until: 1) PERS or the attorney(s)-in-fact has/have actual knowledge of your death, 2) you revoke the power of attorney, 3) your attorney-in-fact relinquishes his/her duties and position, or 4) a power of attorney with a later date is received and accepted from you.

Section B: Attorney-in-fact information

If multiple attorney(s)-in-fact, check one: Either may sign or Both must sign

Attorney-in-fact

Name			
Mailing address (street or PO box)			
City	State	Zip code	
Attorney-in-fact signature (do not print)			Date

1st alternate attorney-in-fact

Name			
Mailing address (street or PO box)			
City	State	Zip code	
1st alternate attorney-in-fact signature (do not print)			Date

Co-attorney-in-fact

Name			
Mailing address (street or PO box)			
City	State	Zip code	
Co-Attorney-in-fact signature (do not print)			Date

2nd alternate attorney-in-fact

Name			
Mailing address (street or PO box)			
City	State	Zip code	
2nd alternate attorney-in-fact signature (do not print)			Date

I, _____ (name of account holder), grant the above named attorney(s)-in-fact power and authority to act on my behalf in all matters associated with my Oregon Public Employees Retirement System (PERS) benefits under ORS Chapter 238 and Chapter 238A, including changes of beneficiary, changes of retirement option, and all matters related to my PERS Health Insurance Program as provided under ORS 238.410 through 238.420, that I would otherwise be able to perform myself. This power of attorney may be revoked at any time through a written notification by the account holder.

The attorney(s)-in-fact may/ may not appoint and substitute for themselves any agent or attorney with the same authority as previously stated. (This substitution may be revoked at any time.)

Office use only	
<input type="checkbox"/> PERS <input type="checkbox"/> OPSRP <input type="checkbox"/> IAP	
<input type="checkbox"/> Member <input type="checkbox"/> Alternate payee	
<input type="checkbox"/> Cross reference member SSN	

Account holder signature (do not print) _____ Date _____

*Providing your Social Security number (SSN) is voluntary. It will be used for confirmation purposes. If you choose not to supply your SSN, it may take PERS staff longer to process your form. In compliance with the Americans with Disabilities Act, PERS will provide help filling out this form upon request. You may request help by calling toll free 888-320-7377 or TTY 503-603-7766.
Form #459-260 (2/13/2017) SL3 IIM Code: 9996