



# Pre-Application for Survivor Retirement Benefits

Form 9A SRVR – Revised 02/11/2026

Please print or type in black ink. Mail or fax completed form to PERS. See bottom of form for contact information.

**1 Deceased Member Information** – To be completed by benefit applicant. Attach a copy of member's birth and death certificates.

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Social Security No.: \_\_\_\_\_ Birth Date mm/dd/ccyy: \_\_\_\_\_ Date of Death mm/dd/ccyy: \_\_\_\_\_  
Marital Status at Death – Select one. Add date for last three.  Single  Married  Divorced  Widowed Effective Date mm/dd/ccyy: \_\_\_\_\_

**2 Retirement Plan** – Select applicable plan.

Public Employees' Retirement System of Mississippi (PERS)  Mississippi Highway Safety Patrol Retirement System (MHSPRS)  
 Supplemental Legislative Retirement Plan (SLRP)

**3 Family Information** – Attach copy of birth certificate for each survivor, marriage certificate for spouse, and separate sheet listing additional children.

Spouse's Full Name	Social Security No.	Birth Date mm/dd/ccyy	Wedding Date mm/dd/ccyy
_____	_____	_____	_____
Dependent Child's Full Name <i>Up to age 19, or 23 if unmarried and a full-time student</i>	Social Security No.	Birth Date mm/dd/ccyy	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**4 Applicant Authorization** – Attach copy of applicant's birth certificate. If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Gender:  M  F  
Social Security No.: \_\_\_\_\_ Birth Date mm/dd/ccyy: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  Cellular  Home  Work Phone: \_\_\_\_\_  Cellular  Home  Work  
Applicant Signature: \_\_\_\_\_ Date mm/dd/ccyy: \_\_\_\_\_

**5 Employer Certification of Member Information** – To be completed by an authorized representative of the employer.  Original  Revised

Position Held/Job Title: \_\_\_\_\_ Status (check all that apply) –  Elected Official  Fee Paid Official  Public Safety Employee  
Official Hire Date mm/dd/ccyy: \_\_\_\_\_ Official Termination Date mm/dd/ccyy: \_\_\_\_\_

I hereby certify that an accident or traumatic event occurred in the performance of duty.  Yes  No If yes, attach copy of Workers' Compensation Report

**Projected Unreported Gross Earnings/Leave Payment/Accumulated Leave** – Project all unreported wages from the month this application is completed through the month the last Wage and Contribution Report will be submitted for this employee. For a deceased member who was an elected official, credit Elected Official Leave by attaching a listing of all dates of elected service and offices held.

**Projected Unreported Gross Earnings**  
Not including leave payment.

MM/CCYY	Earnings to be Reported
_____	\$ _____
_____	\$ _____
_____	\$ _____

**Leave Payment**

Not including compensatory leave payments

Projected **Gross** Unreported Leave Payment, if applicable and for not more than 30 days/240 hours:  
\$ \_\_\_\_\_  
Lump sum leave payment rate of pay:  
\$ \_\_\_\_\_ per  Hour or  Day

**Lawfully Accumulated Unused, Uncompensated Leave (PERS Tiers 1-4 and MHSPRS Only)**

Unused, uncompensated personal and major medical leave:  
\_\_\_\_\_  Hours  Days  
Leave accrual rate annually at termination:  
\_\_\_\_\_  Hours  Days

I understand that any person who makes a false statement or shall falsify or permit to be falsified any record of a retirement plan administered by PERS in an attempt to defraud the plan may be subject to criminal prosecution. With that understanding, I certify that the above information is true and correct.

Employer Name: \_\_\_\_\_ Employer No.: \_\_\_\_\_ - \_\_\_\_\_  
Employer Representative's Name: \_\_\_\_\_ Employer Representative's Title: \_\_\_\_\_  
Employer Representative's Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Employer Representative's Signature: \_\_\_\_\_ Date mm/dd/ccyy: \_\_\_\_\_