ABP-80-66-690-0214

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
NEW JERSEY DIVISION OF PENSIONS AND BENEFITS
ALTERNATE BENEFIT PROGRAM

LEAVE OF ABSENCE OR TERMINATION OF EMPLOYMENT

INTEROFFICE Use Only

ABP# _____

EMPLOYEE SECTION

This is to advise you that:

NAME: _____

MAILING ADDRESS: _____

ABP MEMBERSHIP NUMBER: _____
ASSIGNED BY DIVISION OF PENSIONS AND BENEFITS

SOCIAL SECURITY NUMBER: *(last four digits only)* _____

ANNUAL SALARY: $ _____

EMPLOYER SECTION

Employee has ceased contributing to the Alternate Benefit Program because of:

☐ **ADJUNCT EMPLOYEE:** from: _____ to: _____

☐ **LEAVE OF ABSENCE:**

Reason for Leave of Absence: _____

granted **with** pay effective: _____ through: _____

granted **without** pay effective: _____ through: _____

☐ **TERMINATION OF EMPLOYMENT**— effective: _____

Reason for termination: _____

_____

INVESTMENT CARRIER(s): _____

☐ **SUSPENSION:** from: _____ to: _____

LOCATION NAME: _____ **LOCATION #:** _____

LOCATION PHONE NUMBER: _____

EMPLOYER SIGNATURE: _____
SIGNATURE OF CERTIFYING OFFICER *DATE*