

Affidavit of Attorney-in-Fact

(Attach this Affidavit to the Power of Attorney)

Plan (check one): PERS SERS TRS PSERS LEOFF WSPRS JRS DCP

MEMBER INFORMATION

Member's Name	Member's Social Security Number
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PRINCIPAL'S INFORMATION

Principal's Name	Principal's Social Security Number
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STATEMENT

My name is _____ . I declare that:

1. I am the person designated as Attorney-in-Fact in the ("Name of Document") _____
_____, that was signed by ("Name of Principal")
_____, properly notarized and is attached to this Affidavit. The attached

DOCUMENT is (check one):

- the original.
 a true copy of the original.

2. I have signed this Affidavit freely and voluntarily, to establish my authority to act as the Attorney-in-Fact for the PRINCIPAL to (proposed actions on the principal's account) _____

3. To the best of my knowledge, the PRINCIPAL is still alive.

4. To the best of my knowledge, when the PRINCIPAL signed and had the DOCUMENT notarized, he/she was competent to do so, and signed the DOCUMENT voluntarily.

5. All events needed to make the Power of Attorney effective have happened. The circumstances or conditions stated in the DOCUMENT that would allow me to become the Attorney-in-Fact have happened.

6. I have no actual knowledge that the authority given to me in the DOCUMENT has been revoked, terminated, limited, or modified.

7. I have no actual knowledge of any other circumstances that would limit, change, revoke, or terminate the DOCUMENT or my authority to take the proposed actions described in the DOCUMENT.

8. I WAS WAS NOT married to the PRINCIPAL at the time the DOCUMENT was signed by the PRINCIPAL and was properly notarized. *(If the Attorney-in-Fact chosen WAS married to the PRINCIPAL, go to #9. If NOT, skip #9 and go to #10.)*

9. My marriage to the PRINCIPAL HAS HAS NOT been dissolved or declared invalid.

10. I am the ORIGINAL SUCCESSOR Attorney-in-Fact.

Please continue on reverse side



11. I am the Principal's doctor, doctor's employee, or the owner/administrator/employee of the Principal's long-term health care facility. YES NO

Note: If the answer to this question is "YES," you may not act as Attorney-in-Fact unless you are the Principal's spouse, adult child, brother, or sister.

My relationship to the Principal is: _____

ATTORNEY-IN-FACT INFORMATION

Attorney-in-Fact Mailing Address

City	State	Zip	Attorney-in-Fact Phone Number
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NOTARIZATION OF SIGNATURE

I declare that I am acting in good faith pursuant to my authority under the DOCUMENT. I certify that I will either fax, hand deliver, or mail this original affidavit (postage prepaid) and attachments, to the Washington State Department of Retirement Systems, P.O. Box 48380, Olympia, Washington 98504-8380.

I certify under penalty of perjury, under the laws of the State of Washington, that the statements in this Affidavit are true and correct.

Attorney-in-Fact's signature

Signed on _____, at _____, _____
Date City State

I certify that I know or have reasonable evidence that _____ is the person who appeared before me, and that person stated that he/she signed this document and acknowledged it to be his/her free and voluntary act for the uses and purposes mentioned in the document.

State of _____ County of _____

Signed or attested before me on _____, _____
Day Month Year

Name of Notary Public and Title

Notary Public Signature

My Appointment Expires

Seal
or
Stamp