STRS OHIO
State Teachers Retirement System of Ohio

275 East Broad Street
Columbus, OH 43215-3771
1-888-535-4050
www.strsoh.org/employer

# EMPLOYER CASH RECEIPT REMITTANCE FORM

## Please send check(s) and this form to:
## STRS Ohio, P. O. Box 631135, Cincinnati, OH 45263-1135

***If you are submitting contributions for more than one employer, please complete a separate form for each employer.***
***If you have questions, please call your employer advisor toll-free at 1-888-535-4050 or visit www.strsoh.org/employer.***

## SECTION 1: Employer Information

Employer name: _____

Employer number: _____ _____ _____ _____

## SECTION 2: Payment Method and Amount

❑ Check(s)
Total amount: $ _____

❑ Wire transfer*
Date: _____
Total amount: $ _____

❑ ACH (Automated Clearing House)*
Date: _____
Total amount: $ _____

*Complete a separate form for each wire transfer or ACH.

## SECTION 3: Contribution Amounts Included in Payment

| | **Check number**<br>Leave blank if wire transfer or ACH | **Amount**<br>Complete for check(s), wire transfer or ACH |
|---|---|---|
| ❑ 10% employee contributions<br>Pay date(s): _____ | _____ | $ _____ |
| | _____ | $ _____ |
| | _____ | $ _____ |
| ❑ 14% employer contributions<br>Pay date(s): _____ | _____ | $ _____ |

## SECTION 4: Other Amounts Included in Payment

| | **Check number**<br>Leave blank if wire transfer or ACH | **Amount**<br>Complete for check(s), wire transfer or ACH |
|---|---|---|
| ❑ 3.5% ARP contributions (submit monthly)<br>(College or university ONLY)<br>Fiscal month: _____ | _____ | $ _____ |
| ❑ Payroll deduction for purchase of service credit (submit monthly)<br>(Submit copy of payroll deduction remittance form)<br>Fiscal month: _____ | _____ | $ _____ |
| ❑ Adjustments to member accounts<br>(Submit letter with details of adjustments) | _____ | $ _____ |
| ❑ Payment for invoice<br>(Submit copy of invoice) | _____ | $ _____ |
| ❑ Other _____ | _____ | $ _____ |
| ❑ Other _____ | _____ | $ _____ |

**Total of amounts in Sections 3 and 4 should equal the total payment amount listed in Section 2.**

Date submitted: _____ Signature: _____