



PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction

New Member Enrollment

Form Last Revised: February, 2020

The *New Member Enrollment* Form allows a newly hired employee to apply for membership in a public retirement system. The form must be completed by any new employee regardless of his or her past employment with any governmental entity. Certain information on this form must be provided by the Payroll/Personnel Department and verified by the retirement board.

A new member must also complete the *Beneficiary Selection Form for Refund of Accumulated Deductions* and, if applicable, the *Beneficiary Selection Form (Option D)*.

New Member Enrollment

Form Last Revised: February, 2020

Retirement Board: Please enter your retirement board information here.

Name of Retirement Board:			
Address:			
City/Town:		Zip Code:	
Telephone:		Fax:	

Employee Information

Employee Last Name:		First Name:		M.I.:	
Social Security # (Entire #):		Phone #:		Sex:	
Street Address:					
City/Town:		State:		Zip Code:	
Birth/Former Name (if different)		Email:			
Date of Birth*:		Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced*
Spouse's Name:		Spouse's DOB:		# of Children:	

Your Retirement Board will request a copy of birth records, military discharge papers and other pertinent data.

*If Divorced and you have a Qualified Domestic Relations Order (QDRO), please attach a copy.

Current/Prior Retirement System Membership

List prior or current public retirement system membership:

Are you retired from any other Massachusetts public retirement system? YES NO

Were you ever a member of any other Massachusetts public retirement system? YES NO

List prior or current public retirement system membership:

SYSTEM	DATES OF MEMBERSHIP		ARE YOUR FUNDS STILL ON DEPOSIT?	
	From:	To:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
			<input type="checkbox"/> YES	<input type="checkbox"/> NO
			<input type="checkbox"/> YES	<input type="checkbox"/> NO
			<input type="checkbox"/> YES	<input type="checkbox"/> NO

If you wish to purchase past creditable service, please ask your Retirement Board about your options.

Did you ever work for or do you currently work for the Commonwealth or one of its political subdivisions for which you were not/are not a contributing member of a retirement system? YES NO

Member Last Name: First Name: SSN: ***-**-____

Other Public Employment in Massachusetts

List prior or current public employment in Massachusetts or one of its political subdivisions (Non-membership):

EMPLOYER	DATES OF EMPLOYMENT	
	From:	To:

Veteran Status

Are you a veteran? YES NO

If **YES**, please enter dates of service and attach a copy of your military discharge papers, Forms DD-214, DD-215, DD-256, NGB 22, or NGB 22A.

DATES OF ACTIVE SERVICE	
From:	To:

I hereby authorize the Treasurer to withhold the proper percentage of my regular compensation due on each pay period and to deposit such deductions to my credit in the annuity savings fund. I understand the full amount of such deductions, with regular interest as provided by law, will be returned to me upon my written request if I terminate my service, unless I plan to accept a position which would entitle me to become a member of any other contributory retirement system in the Commonwealth or other conditions apply. In the event that I die before retiring, my named beneficiary or beneficiaries may receive survivor benefits **OR** a refund of my accumulated total deductions as allowed by law.

I sign this application under the penalties of perjury. I affirm that the information presented in this application is correct, complete and accurately presented. I understand that giving false or incomplete information may subject me to the loss of my benefits as well as civil and criminal penalties.

Applicant's Signature:

Print Employee's Name:

Employee's Signature: Date:

Member Last Name: First Name: SSN: ***-**-_____

Payroll/Personnel Department

To be completed by Payroll/Personnel Department and verified by Retirement Board:

Check base rate to be deducted for retirement:

5% 7% 8% 9% Additional 2%

If 5%, 7%, or 8%, state reason:

Current Rate of Regular Compensation per Pay Period: \$

Employment Status (Check ALL that apply):

Permanent Temporary Full-time Part-time 50% 75% Other:

Agency/Dept: Title/Position:

Starting Date of Present Position:

Authorized Signature: Date:

Print Name:

Retirement Board

To be completed by Retirement Board:

Membership Date:

Annual Regular Compensation: \$

% to be Deducted

Current Group Classification:

The member should also complete the *Beneficiary Selection Form (Refund)* or if applicable, the *Beneficiary Selection Form (Option D)*.



Introduction

Beneficiary Selection Form for Refund of Accumulated Deductions (If Member Dies Before Retirement)

Pursuant to Massachusetts General Laws, Chapter 32, Section 11(2)(c)

Form Last Revised: February, 2020

The *Beneficiary Selection Form for Refund of Accumulated Deductions* allows a member to select a beneficiary or beneficiaries to receive payment of accumulated deductions and other payments due a member if the member dies before retirement, as described at Massachusetts General Laws, Chapter 32, Section 11(2)(c).

The following needs to be kept in mind:

- This form must be filed with the retirement board.
- If you have designated an eligible beneficiary who is alive at the time of your death on the *Beneficiary Selection Form for Option D*, then the money in your annuity account will not be disbursed to anyone in a one-time lump-sum payment, even if you have designated them on this form.
- Any person or entity may be designated as your Refund of Accumulated Deductions beneficiary under Section 11(2)(c). You may designate multiple beneficiaries and must indicate the percentage of the annuity account that you wish each beneficiary to receive. The percentages must total 100%.
- Your selection of a beneficiary on this form also may be superseded by an eligible spouse under the provisions of Option D.
- If your personal situation changes (e.g. divorce, a domestic relations order goes into effect, your beneficiary dies), you should file a new form with your retirement board.
- If you file a new Section 11(2)(c) form with your retirement board, it will supersede any and all prior Section 11(2)(c) forms filed previously by you.
- When you sign this form, it should be witnessed by a disinterested party.
- This form becomes void upon your retirement.

Beneficiary Selection Form for Refund of Accumulated Deductions (If Member Dies Before Retirement)

Pursuant to Massachusetts General Laws, Chapter 32, Section 11(2)(c)

Form Last Revised: July, 2019

Retirement Board: Please enter your retirement board information here.

Name of Retirement Board:	<input type="text"/>		
Address:	<input type="text"/>		
City/Town:	<input type="text"/>	Zip Code:	<input type="text"/>
Telephone:	<input type="text"/>	Fax:	<input type="text"/>

Member's Information:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Member's Last Name	Member's First Name	Social Security # (last four)	
Street Address:	<input type="text"/>		
City/Town:	<input type="text"/>	State:	<input type="text"/>
Email:	<input type="text"/>		
Phone:	<input type="text"/>	<input type="text"/>	

Choice of Beneficiary or Beneficiaries to Receive a Refund of Accumulated Total Deductions at Member's Death:

- Any person or entity may be a beneficiary under Massachusetts General Laws, Chapter 32, Section 11(2)(c). Give complete name and address of each beneficiary on the next page.

I, (Print Name) , a member of the
Retirement System hereby request the Retirement Board to pay any sum referred to in Massachusetts General Laws, Chapter 32, Section 11(2)(c) due at my death to the following beneficiary or beneficiaries in the proportions designated on the next pages.

Beneficiary Selection Form for Refund of Accumulated Deductions

Member Last Name: First Name: SSN: ***-**-____

PRIMARY LUMP-SUM BENEFICIARY(IES)

Do NOT name any one person or entity as a beneficiary more than ONCE in this section.

Primary Lump-Sum Beneficiary Information:

Primary Lump-Sum Beneficiary Information:			% of Benefit**
Full Name: (First, MI, Last):	SSN/EIN*:		
Relationship to You:	Phone:	Date of Birth:	
Address:			
Full Name: (First, MI, Last):	SSN/EIN*:		
Relationship to You:	Phone:	Date of Birth:	
Address:			
Full Name: (First, MI, Last):	SSN/EIN*:		
Relationship to You:	Phone:	Date of Birth:	
Address:			
Full Name: (First, MI, Last):	SSN/EIN*:		
Relationship to You:	Phone:	Date of Birth:	
Address:			
Full Name: (First, MI, Last):	SSN/EIN*:		
Relationship to You:	Phone:	Date of Birth:	
Address:			

*Beneficiary's full Social Security Number (SSN) or Employer Identification Number (EIN), if an organization.

**Total must equal 100%; if no percentages are indicated, benefit will be allocated equally among lump-sum beneficiaries.

%

CONTINGENT LUMP-SUM BENEFICIARY(IES)

In the event that none of the named primary lump-sum beneficiary(ies) above, are alive, or, if an organization, still operating, as of your death.

Contingent Lump-Sum Beneficiary Information:

Contingent Lump-Sum Beneficiary Information:			% of Benefit**
Full Name: (First, MI, Last):	SSN/EIN*:		
Relationship to You:	Phone:	Date of Birth:	
Address:			
Full Name: (First, MI, Last):	SSN/EIN*:		
Relationship to You:	Phone:	Date of Birth:	
Address:			
Full Name: (First, MI, Last):	SSN/EIN*:		
Relationship to You:	Phone:	Date of Birth:	
Address:			
Full Name: (First, MI, Last):	SSN/EIN*:		
Relationship to You:	Phone:	Date of Birth:	
Address:			
Full Name: (First, MI, Last):	SSN/EIN*:		
Relationship to You:	Phone:	Date of Birth:	
Address:			

*Beneficiary's full Social Security Number (SSN) or Employer Identification Number (EIN), if an organization.

**Total must equal 100%; if no percentages are indicated, benefit will be allocated equally among lump-sum beneficiaries.

%

Beneficiary Selection Form for Refund of Accumulated Deductions

Member Last Name: First Name: SSN: ***-**-_____

I understand that my selection may be superseded if I die with an eligible beneficiary under Option D.

I understand that I may change my beneficiary designation at any time prior to my retirement and that upon my retirement, this form becomes void.

The types of payments covered under Massachusetts General Laws, Chapter 32, Section 11(2)(c) include:

- The one-time payment of the accumulated deductions credited to a member's account in the annuity savings fund at the date of death when the member's death occurs prior to his/her retirement.
- Any amounts payable to a member at his or her death.

Member's Signature:

Print Name:

Signature: Date:

To Be Completed By Witness (should be disinterested party):

Name (Print):

Street Address:

City/Town: State: Zip Code:

Signature: Date: