



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

# Introduction

## **Beneficiary Change Form - Option B (If Member Dies After Retirement)**

Pursuant to Massachusetts General Laws, Chapter 32, Sections 11(2)(b) and 12(2)(b)

Form Last Revised: February, 2020

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The *Beneficiary Change Form - Option B* allows a retired member to select a beneficiary or beneficiaries to receive payment of any accumulated deductions remaining in his/her account when the member dies after retirement.

Keep in mind:

- Any person, persons or entity can be named as an Option B beneficiary.
- Option B beneficiary(ies) can be changed at any time.
- Your selection on this form will supersede any earlier beneficiary(ies) selected by you.

# Beneficiary Change Form - Option B (If Member Dies After Retirement)

Pursuant to Massachusetts General Laws, Chapter 32, Sections 11(2)(b) and 12(2)(b)

Form Last Revised: July, 2019

2

**Retirement Board:** Please enter your retirement board information here.

|                                  |  |                  |  |
|----------------------------------|--|------------------|--|
| <b>Name of Retirement Board:</b> |  |                  |  |
| <b>Address:</b>                  |  |                  |  |
| <b>City/Town:</b>                |  | <b>Zip Code:</b> |  |
| <b>Telephone:</b>                |  | <b>Fax:</b>      |  |

## Member's Information:

|                           |                            |                                      |
|---------------------------|----------------------------|--------------------------------------|
|                           |                            | ***_**_                              |
| <b>Member's Last Name</b> | <b>Member's First Name</b> | <b>Social Security # (last four)</b> |
| <b>Street Address:</b>    |                            |                                      |
| <b>City/Town:</b>         | <b>State:</b>              | <b>Zip Code:</b>                     |
| <b>Email:</b>             |                            |                                      |
| <b>Phone:</b>             |                            |                                      |

## Choice of Beneficiary to Receive a Return of Accumulated Total Deductions Remaining in a Member's Annuity Account at Member's Death

I, (Print Name) , a member of the Retirement System, have chosen to be retired under the provisions of Massachusetts General Laws, Chapter 32, Section 12(2)(b) ("Option B"). I hereby request that the retirement board pay any sum payable under that section of the law to the beneficiary or beneficiaries I have listed on the following page.

The amounts payable under Option B consist of:

- The payment of any accumulated deductions credited to a retired member's account in the annuity reserve fund at the date of death.
- The amount of any pro-rata share of retirement allowance due to the member on the date of his/her death.

I understand that I may change this beneficiary designation at any time by filing a new *Beneficiary Change Form - Option B*.

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

**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.

%

**Member's Signature:**

Name (Print):

Signature:  Date:

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

Name (Print):

Street Address:

City/Town:  State:  Zip Code:

Signature:  Date: