



THE COMMONWEALTH OF MASSACHUSETTS

State Retirement Board

ONE WINTER STREET, 8TH FLOOR, BOSTON, MA 02108
436 DWIGHT STREET, #109A, SPRINGFIELD, MA 01103

2015 EMPLOYEE RETIREMENT INCENTIVE PROGRAM (“ERIP”) INFORMATION SHEET/APPLICATION

NOTE: INCOMPLETE APPLICATION FORMS WILL NOT BE ACCEPTED OR PROCESSED DUE TO THE EXPECTED HIGH VOLUME OF SUBMISSIONS AND THE ALLOTTED SHORT TURNAROUND TIME.

ELIGIBILITY REQUIREMENTS:

- Employee must be employed as of the effective date of this act (**Chapter 19 of the Acts of 2015**), May 04, 2015 and through the date of retirement, June 30, 2015, by an Executive Department agency, bureau, department, office or division of the commonwealth within or under the control of the governor or a secretary of an executive office, or must be employed by the Office of the Governor.
- Employee must be a member in service of the state retirement system and must be classified in Group 1 as of the effective date of this act, May 04, 2015. (Subject to Board verification.)
- Employee must have a minimum of 20 years of creditable service at any age, or minimum of 10 years of creditable service and be 55 years of age or older by the effective date of this act, May 04, 2015.
- The Massachusetts State Retirement Board must receive an eligible employee’s application starting on or after Monday May 11, 2015 but not later than Friday June 12, 2015.** The retirement date requested in the application shall be **June 30, 2015**.
- Completed Application, **must include** Payroll Certification, Counseling, and Sick & Vacation Payment Consent Form. **A member will be ineligible for the Retirement Incentive Program if these forms are not included in the Application.**
- The following categories of employees are not eligible:**
 - (i) employees whose compensation is funded from a federal grant, trust, or capital appropriation;
 - (ii) elected officials;
 - (iii) employees currently being reinstated under G.L. c.32, §105 and members who attained age 70 and have ceased contributing to the retirement system pursuant to section 90G3/4;
 - (iv) employees who have been designated by the secretary of administration and finance to hold a “critical position” as that term is defined in c. 19 of the Acts of 2015.

BENEFITS:

- The incentive provides up to an additional five (5) years of creditable service, or of age, or some combination of the two, in full year increments, not to exceed five for any eligible member.
- Benefit calculation **will not include *prorated*** creditable service previously provided in **Group 2, Group 3, and/or Group 4.**
- Employees **may not** seek to utilize the “spousal benefit.”

2015 EMPLOYEE RETIREMENT INCENTIVE PROGRAM (ERIP) APPLICATION

THINGS TO REMEMBER:

- The State Retirement Board will make all final group classification decisions pursuant to its **Group Classification Policy**. You may be required to complete a **2015 ERIP Group Classification Questionnaire** for Board review.
- Your first payment will be retroactive to your retirement date of June 30, 2015. **Due to the expected high volume of retirement applications it is likely your first benefit payment will be direct deposited (90) ninety to (120) one hundred and twenty days after your retirement date.** Direct deposit is credited the last business day of the month. **Please plan accordingly.**
- A request to withdraw a retirement application or a request to change Option selection must be made in writing and received by the State Retirement Board **BEFORE JUNE 30, 2015**.
- A request to withdraw a retirement application or a request to change Option selection **may not be made AFTER JUNE 30, 2015**.
- An employee retired under this act may not be re-employed in the service of the commonwealth, including as a consultant or independent contractor, or in any other capacity within 30 days of the retirement date JUNE 30, 2015 by an employee's agency.
- Payments in lieu of any accrued vacation time and any unused sick leave shall be made in three installments on September 1, 2015, July 1, 2016, and July 1, 2017.

COUNSELING:

- Counseling will be available at the State Retirement Board Offices:
 - One Winter Street, 8th Floor, Boston, MA 02108;
 - 436 Dwight Street, #109A, Springfield, MA
 - By phone at (617) 367-7770, or 1-800-392-6014 (within Mass).

BUYBACKS (SERVICE PURCHASES):

If you have prior public service that you wish to purchase, please fill out an applicable Buyback Request Form and submit it with this application. Buyback forms are posted on our website, mass.gov/retirement.

Please Note: Payments for any outstanding service purchases or any other funds owed to the State Retirement Board must be completed **before** any retirement benefit will commence.

2015 EMPLOYEE RETIREMENT INCENTIVE PROGRAM (ERIP) APPLICATION

APPLICATION INSTRUCTIONS:

NOTE: INCOMPLETE APPLICATION FORMS WILL NOT BE ACCEPTED OR PROCESSED DUE TO THE EXPECTED HIGH VOLUME OF SUBMISSIONS AND THE ALLOTTED SHORT TURNAROUND TIME.

A fully completed application form must be received by the State Retirement Board no later than **JUNE 12, 2015**.

NOTE: A fully completed form includes the following:

- Copy of employee's birth certificate or copy of passport.
- Option Selection Form A, B, or C. If married, a spouse must witness Option Selection Form. **By witnessing the Option, the spouse is confirming he or she understands the Option selection.**
- If member is selecting Option C, a copy of beneficiary's birth certificate, and a copy of marriage certificate if the spouse is the beneficiary. If the beneficiary is a former spouse, the spouse must be unmarried on the date of the member's retirement.
- Completed Payroll Certification, Sick & Vacation Payment Consent, and Counseling Forms.
- If you are a party to a Court approved Qualified Domestic Relations Order ("QDRO") please include a copy with your application
- W-4P Federal Tax Withholding Form indicating option for federal income tax purposes.
- Copy of Veteran's DD-214, if applicable.

SUBMIT YOUR COMPLETED APPLICATION TO THE STATE RETIREMENT BOARD NO LATER THAN JUNE 12, 2015 TO ONE OF THE FOLLOWING:

**One Winter Street, 8th Floor, Boston, MA 02108, or
436 Dwight Street, Room #109A, Springfield, MA 01103, or
Electronically via e-mail to 2015ERIP@tre.state.ma.us***

***Electronic submission disclaimer:**

The State Retirement Board and the Department of Treasury disclaims any liability for the improper or misuse of information submitted through the electronic address referenced herein, and do not provide any warranty or guarantee, express or implied, including but not limited to implied warranties of non-infringement or fitness for particular purpose, nor any warranties as to the accuracy, timeliness, quality, security, reliability, performance, completeness or suitability related to the manner by which any information and materials may be submitted to the electronic address referenced herein. You agree that the State Retirement Board and the Department of Treasury shall not be responsible for any direct, indirect, special, or consequential damages, or loss of data arising from or relating to your submission of information to the electronic address utilized herein.

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2015 EMPLOYEE RETIREMENT INCENTIVE PROGRAM (ERIP) APPLICATION



State Retirement Board

ONE WINTER STREET, 8TH FLOOR, BOSTON, MA 02108
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PAYROLL CERTIFICATE / SICK AND VACATION PAYMENT CONSENT FORM

PLEASE NOTE: FAILURE TO COMPLETE PARTS 1 AND 2 BELOW WILL RENDER YOU INELIGIBLE TO PARTICIPATE IN THE 2015 EMPLOYEE RETIREMENT INCENTIVE PROGRAM AND YOUR APPLICATION WILL NOT BE ACCEPTED AND/OR PROCESSED.

1. TO BE COMPLETED BY THE PAYROLL OFFICER OR HR DIRECTOR

Employees whose compensation is funded from a federal grant, trust, or capital appropriation, each as defined in section 1 of chapter 29 of the Massachusetts General Laws are not eligible to receive any benefit from the 2015 Employee Retirement Incentive Program.

A) This employee's position _____ *has not been deemed to be a critical position,*
(Official Job Title)
pursuant to **Chapter 19 of the Acts of 2015.**

B) A review of the available payroll records of _____ of the
(Name of Employee)
_____ indicates that *this employee's compensation is not funded from a federal*
(Agency/Department)
grant, trust, or capital appropriation.

X

SIGNATURE OF PAYROLL
OFFICER OR HR DIRECTOR

DATE

2. PAYMENT IN LIEU OF SICK LEAVE & VACATION TIME CONSENT (TO BE COMPLETED BY EMPLOYEE)

I (print name), _____ understand and agree to receive any payment in lieu of my accrued vacation time, unused sick leave or other benefit, otherwise due in accordance with the General Laws of the Commonwealth, to be paid out in three yearly installments, as set forth under **Chapter 19 of the Acts of 2015** on the following dates:

- 1/3 of such payment on September 1, 2015
- 1/3 of such payment on July 1, 2016
- 1/3 of such payment on July 1, 2017

I further understand that without signing this consent form as part of my retirement application, I am ineligible to participate in the 2015 Employee Retirement Incentive Program, as set forth under Chapter 19 of the Acts of 2015.

X

MEMBER SIGNATURE

DATE

SSN:

Employee ID:

Address:

Union Affiliation (if any):

Agency Employed By:

NAME OF UNION AND LOCAL NUMBER

2015 EMPLOYEE RETIREMENT INCENTIVE PROGRAM (ERIP) APPLICATION



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COUNSELING CONSENT FORM

PLEASE NOTE: FAILURE TO COMPLETE PARTS 1 AND 2 OF THIS FORM WILL RENDER YOU INELIGIBLE TO PARTICIPATE IN THE 2015 EMPLOYEE RETIREMENT INCENTIVE PROGRAM AND YOUR APPLICATION WILL NOT BE ACCEPTED AND/OR PROCESSED.

1. COUNSELING CONSENT - MASSACHUSETTS STATE RETIREMENT BOARD (MSRB)

I (print name), _____ understand counseling will be provided upon my request.

Please Check Appropriate Box:

- I Received Counseling
 I Do Not Want Counseling

X

MEMBER SIGNATURE

DATE

2. COUNSELING CONSENT - GROUP INSURANCE COMMISSION (GIC)

I (print name), _____ understand counseling by Group Insurance Commission regarding the provision of health insurance and other GIC benefits will be provided upon my request.

Please Check Appropriate Box:

- I Received Counseling
 I Do Not Want Counseling

X

MEMBER SIGNATURE

DATE

IF YOU HAVE FURTHER QUESTIONS, YOU MAY CONTACT THE GROUP INSURANCE COMMISSION AT (617) 727-2310 EXT. 1 OR 6, OR VISIT THEIR WEBSITE AT WWW.MASS.GOV/GIC.

2015 EMPLOYEE RETIREMENT INCENTIVE PROGRAM (ERIP) APPLICATION
PLEASE COMPLETE ALL REQUIRED SECTIONS. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED!



State Retirement Board

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RETIREMENT APPLICATION

1. MEMBER INFORMATION (REQUIRED)

I respectfully request superannuation under the provisions of Section 1 to 28 inclusive of Massachusetts General Laws Chapter 32.

Name: _____ SSN: _____

I wish to retire on: **06/30/2015** with _____ years and _____ months of service (do not include incentive)

All Former Names: _____

Date of Birth: (Proof of Birth Required) _____ Are You a Veteran? No Yes (include copy of DD-214)

Marital Status: Single Married Divorced Gender: M F

Current or Last Place of State Employment: _____

Position/Title: _____

Retirement Group* (If Known): 1 2 3 (State Police only) 4

*Note: Subject to Board verification. Upon review, the Board MAY require you to submit a Group Classification Questionnaire.

2. CONTACT INFORMATION (REQUIRED)

Present Address: _____ E-Mail Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Address after Retirement (If Different): _____

City: _____ State: _____ Zip: _____

3. SPOUSE INFORMATION (IF APPLICABLE)

Spouse's Name: _____

Spouse's Address (If Different): _____

City: _____ State: _____ Zip: _____

4. MEMBER SIGNATURE (REQUIRED - APPLICATION WILL NOT BE PROCESSED WITHOUT SIGNATURE)

- All statements on this application are true statements made under the penalties of perjury.
- I understand that **no changes can be made to my retirement** or to my option selection after my retirement date.
- I understand that there are three (3) retirement OPTIONS - A, B, or C - and that if I do not choose an option by completing the Option Selection Form on page 3, I will be automatically retired under OPTION B.

SIGN HERE: X

MEMBER SIGNATURE

DATE

2015 EMPLOYEE RETIREMENT INCENTIVE PROGRAM (ERIP) APPLICATION

PLEASE COMPLETE ALL REQUIRED SECTIONS. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED!

MEMBER NAME: _____

SSN: _____

5. LIST ALL SERVICE WITH STATE, CITY OR COUNTY GOVERNMENT (REQUIRED*)

Department or Subdivision:	Start Date:	Date Service Ended:

*use additional sheet if necessary

6. MEMBER QUESTIONNAIRE (REQUIRED)

A. Have you ever been convicted of an offense involving the funds or property of your place of employment? No Yes

B. Have you ever been convicted of an offense involving your position while in state service? No Yes

If yes to either of the above, please describe the offense(s): _____

C. Have you ever taken a refund? No Yes

C-1. If YES, from which retirement system?

(Name of Retirement System)

C-2. Do you wish to buy back time? No Yes

(If yes, please complete an applicable Buyback Request Form and submit it with this application.)

C-3. Have you completed a buyback? No Yes

C-4. Do you have a buyback in progress? No Yes

D. Have you ever been on an industrial accident leave? No Yes If YES, what years? _____

E. If divorced, are you a party to a Qualified Domestic Relations Order ("QDRO")? No Yes Don't Know

(If Yes, please include a copy of your QDRO)

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RETIREMENT OPTION SELECTION FORM

MEMBER NAME: _____

SSN: _____

1. CHOOSE ONE OPTION (REQUIRED)

READ THE OPTION PROVISIONS ON THE FOLLOWING PAGE AND CHECK BOX A, B, OR C.

A **OPTION A - No Survivor Retirement Benefits**

I request my pension be paid in accordance with Option A as provided in Section 12, subsection 2 of Chapter 32.
If choosing A, **please complete sections 2 and 3 on this page. Do not complete section 4.**

B **OPTION B - Lump Sum Payment to Beneficiary in Event of Early Death**

I request my pension be paid in accordance with Option B as provided in Section 12, subsection 2 of Chapter 32.
If choosing B, **please complete sections 2, 3, and 4 (beneficiary information on following page).**

C **OPTION C - Joint Survivor Allowance**

I request my pension be paid in accordance with Option C as provided in Section 12, subsection 2 of Chapter 32.
If choosing C, **please complete beneficiary information below and sections 2 and 3. Do not complete section 4.**

OPTION C BENEFICIARY INFORMATION (REQUIRED ONLY IF CHOOSING OPTION C):

Please **do not** complete this section if selecting Option B. A copy of the beneficiary's birth certificate and if spouse, a copy of your marriage license is required if Option C is selected and must be included with this application.

Option C Beneficiary: _____

SSN: _____

(Please print)

Gender: M F

Date of Birth: _____

Relationship to Member: _____

Address/City/State/Zip: _____

2. MEMBER SIGNATURE (REQUIRED)

I have read and understand the provisions of Option _____ selected above.
(enter option selection: A, B, or C)

MEMBER SIGNATURE: X

DATE: _____

3. WITNESS SIGNATURE (REQUIRED)

If married, the witness must be your spouse. Witness CANNOT be a beneficiary unless the witness is your spouse.

WITNESS SIGNATURE: X

DATE: _____

Print Name: _____

Address: _____

PLEASE COMPLETE SECTION 4 ON FOLLOWING PAGE ONLY IF SELECTING OPTION B.

2015 EMPLOYEE RETIREMENT INCENTIVE PROGRAM (ERIP) APPLICATION

PLEASE COMPLETE ALL REQUIRED SECTIONS. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED!

MEMBER NAME:

SSN:

Complete this section ONLY if you are selecting Option B:

4. BENEFICIARY(IES) INFORMATION (REQUIRED IF OPTION B IS SELECTED, PLEASE PRINT)

I.	Name:	Designation:	Proportion: *	Beneficiary Social Security #:
	Street:	<input type="checkbox"/> Primary	<input type="checkbox"/> All	Relationship:
	City, State, ZIP:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % (percent)	Date of Birth:
II.	Name:	Designation:	Proportion: *	Beneficiary Social Security #:
	Street:	<input type="checkbox"/> Primary	<input type="checkbox"/> All	Relationship:
	City, State, ZIP:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % (percent)	Date of Birth:
III.	Name:	Designation:	Proportion: *	Beneficiary Social Security #:
	Street:	<input type="checkbox"/> Primary	<input type="checkbox"/> All	Relationship:
	City, State, ZIP:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % (percent)	Date of Birth:
IV.	Name:	Designation:	Proportion: *	Beneficiary Social Security #:
	Street:	<input type="checkbox"/> Primary	<input type="checkbox"/> All	Relationship:
	City, State, ZIP:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % (percent)	Date of Birth:
V.	Name:	Designation:	Proportion: *	Beneficiary Social Security #:
	Street:	<input type="checkbox"/> Primary	<input type="checkbox"/> All	Relationship:
	City, State, ZIP:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % (percent)	Date of Birth:

***The total of all proportions for your primary and contingent beneficiary(ies) must equal 100% each.**

OPTION PROVISIONS

OPTION A - THERE ARE NO SURVIVOR RETIREMENT BENEFITS

As provided in Section 12, subsection 2 of Chapter 32, by selecting this option, upon my death, I relinquish all claims to the total contributions and the total interest that have been credited to my account. I understand my estate will receive only a prorated amount of my monthly allowance for the number of days I live in the month of my death. ***There are no survivor benefits.***

OPTION B - LUMP SUM PAYMENT TO BENEFICIARY IN EVENT OF EARLY DEATH

As provided in Section 12, subsection 2 of Chapter 32, by selecting this option, I will receive a reduced monthly retirement allowance for life. I also understand that upon my death, if there is a remaining balance in my account - deposits and interest - it will be refunded to my beneficiary(ies) or estate in a lump sum. A prorated amount of my monthly allowance for the number of days I live in the month of my death will go to my estate. I understand that the annuity portion of my allowance is reduced each month. ***If my annuity savings account is depleted at the time of my death, I understand that there will be no survivor benefits.***

OPTION C - JOINT SURVIVOR ALLOWANCE

As provided in Section 12, subsection 2 of Chapter 32, ***by selecting this option, I will receive a reduced retirement allowance for life.*** I also understand that my named beneficiary will receive two-thirds of my retirement allowance upon my death for his or her lifetime, and I understand should the named beneficiary predecease me, my allowance will revert to Option A. An eligible beneficiary may be a spouse, unmarried former spouse (at date of retirement), child, father, mother, brother, or sister. A prorated amount of my monthly allowance for the number of days I live in the month of my death will go to my estate.

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FEDERAL TAX WITHHOLDING W-4P FORM

If a W-4P federal income tax withholding statement is not filed, federal income tax withholding will be calculated as if you are married with three (3) exemptions.

MEMBER INFORMATION (REQUIRED)

Print Name

Social Security Number

Address/City/Town/State/Zip

PLEASE CHECK BOX 1, 2, OR 3 AND COMPLETE CORRESPONDING INFORMATION: (REQUIRED)

1

I do not wish to have federal tax withheld from my benefit. I realize that I am liable for payment of federal income tax on the taxable portion of my pension and that I may be subject to pay penalties under the estimated tax payment rules if my payments of estimated tax and withholding are not adequate.

2

The following exemptions are being claimed and I wish to have the Plan Administrator determine the amount, if any, of federal income tax to be withheld in accordance with the tax tables and exemptions claimed below.

A) Marital Status:

- Single
 Married
 Married, but withhold at higher single rate _____

B) Total exemption you wish to claim: _____

C) In addition to the above amount withhold an additional \$ _____ per month.

3

I wish to have a flat rate of \$ _____ per month withheld.

SIGNATURE: (required)

X

MEMBER SIGNATURE

DATE

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DIRECT DEPOSIT AUTHORIZATION FORM

SECTION A (REQUIRED)

Name:		
Address:		
City:	State:	Zip:
Phone:	Email:	
SS#	Member ID (if known):	

SECTION B (REQUIRED)

Name of Financial Institution:									
All Names on Account:									
Routing #:									
Depositor Account #:									
Please Check Appropriate Box: <input type="checkbox"/> Savings Account <input type="checkbox"/> Checking Account (attach voided check to back)									
Are you receiving direct deposit in this account as an active employee of the Commonwealth? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A									
IF DEPOSITING INTO A CHECKING ACCOUNT, ATTACH A VOIDED CHECK TO THE BACK OF THIS FORM (PAGE 8)									
<input type="checkbox"/>	Check box if any of the above direct deposit will go directly to a foreign bank or if the entire amount is forwarded from a domestic bank to a foreign bank.								

“I (print name), _____ hereby authorize the State Treasurer to deposit my retirement benefit into my account at the financial institution named above. The State Treasurer is also authorized to debit or credit my account, to adjust any over deposit which it has caused to be made to my account. This authorization will remain in effect until revoked by me with thirty (30) days written notice to the Treasurer and Receiver General, One Winter Street, 8th Floor, Boston, MA 02108, or by the State Treasurer.

I certify that I am the person entitled to receive the payment under this application. I also certify that the information herein provided is accurate to the best of my knowledge.”



 SIGNATURE

 DATE

DIRECT DEPOSIT IS MANDATORY FOR ALL MEMBERS RETIRING AFTER JANUARY 1, 2010.
STATEMENTS CAN BE VIEWED ON-LINE AT MASS.GOV/PAYINFO.

2015 EMPLOYEE RETIREMENT INCENTIVE PROGRAM (ERIP) APPLICATION

PLEASE COMPLETE ALL REQUIRED SECTIONS. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED!

MEMBER NAME:

SSN:

**TAPE VOIDED CHECK IN THE SPACE BELOW.
PLEASE DO NOT STAPLE.**

John S. Retireman
55 Easy St.
Anytown, MA XXXXX

0101

Pay to the Order of _____

\$ _____

_____ Dollars

FINANCIAL INSTITUTION
Anytown, MA XXXXX

Memo _____ MP

⑆ 1 2 3 4 5 6 7 8 9 0 ⑆ 0 3 3 3 1 2 3 ⑆ 4 5 6 ⑆ 7 ⑆

Attach voided check in the space above. Please make sure the account number, routing number, name, and address are clearly visible.