PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
10 CABOT ROAD, SUITE 300 | MEDFORD, MA 02155

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

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.

Retirement Board: Please enter your retirement board information here.

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

Member's Information:

		***-**-____ ____ ____ ____
Member's Last Name	**Member's First Name**	**Social Security # (last four)**

Street Address:					
City/Town:		**State:**		**Zip Code:**	
Email:					
Phone:					

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*.

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:						
						0 %

*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 beneficaries.

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:** ______