



MAIL your completed, original form to our main office (address above). Do NOT fax or email your form - we need your original signature, and will not accept your form via fax or email.

1. BENEFIT RECIPIENT INFORMATION (required)


Page 1 of 2

Name:		
Address:		
City:	State:	Zip:
Telephone:	Email Address:	
(Last four digits of Social Security number ONLY) XXX-XX-	MSRB ID # (if known):	

2. CURRENT / OLD ACCOUNT INFORMATION (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									

3. NEW ACCOUNT INFORMATION (required)

Name of Financial Institution:	
All Names on Account:	
Routing #:	
Depositor Account #:	
Indicate account type (check one)	ATTACH this required documentation
<input type="checkbox"/> Checking	An original VOIDED check that is imprinted with your name, address, bank name and routing number, and account number. Temporary or starter checks will not be accepted. If you do not have checks personalized with your name and address, you must attach your bank's signed, official account verification document. 
<input type="checkbox"/> Savings	Your bank's signed, official account verification document indicating your name, address, bank name and routing number, and account number. A deposit slip will not be accepted.
Indicate account ownership (check one)	
<input type="checkbox"/> Individual:	
<input type="checkbox"/> Joint: (ALL additional joint account holders (other than the Benefit Recipient) MUST complete and sign Part 5 on Page 2.)	
<input type="checkbox"/> I am the benefit recipient's Power of Attorney (POA), Guardian, or Conservator. (You MUST also complete Part 4 and 6.)	
<input type="checkbox"/> Trust: ATTACH a Certification of Trust that names the benefit recipient as a trustee or a beneficiary of the trust, and check this box. <input type="checkbox"/>	
Are you receiving more than one type of monthly benefit from the MSERS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes , indicate to which benefit(s) you wish to apply these direct deposit instructions. If none is selected, all benefits will be updated.	
<input type="checkbox"/> Retirement benefit	<input type="checkbox"/> Survivor benefit <input type="checkbox"/> Alternate Payee benefit under a Domestic Relations Order

"I, _____ 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, and to obtain any nonpublic personal information related to me on record with above financial institution. 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."

*Original Signature Required**

Signature - DO NOT PRINT YOUR NAME

Date

***A computer generated or other non-original signature is NOT acceptable.**

PLEASE COMPLETE PART 5 OR 6 BELOW (if applicable)

5. JOINT ACCOUNT HOLDERS' INFORMATION AND CERTIFICATION (if applicable)

If your payment is being deposited to a JOINT account, Part 5 must be completed and signed by ALL other account holders. If there are more than two other account holders, attach additional copies of Part 5.

By signing below, and as a party to this account, I understand that I am personally liable, both individually and as a member of the group of parties to this account, to the Massachusetts State Employees' Retirement System (MSERS), which has the legal obligation to recover any overpayment, for the repayment of any monies deposited to this account to which the benefit recipient named on page 1 is not legally entitled. If I am entitled to any benefit from the MSERS as a beneficiary of the benefit recipient, the amount of my liability may be deducted from the amount payable to me. I agree that the financial institution shall have the right of offset for such a refund and I authorize the financial institution to provide the MSERS with my home address. I release the MSERS, the financial institution, and their respective employees, from any and all liability, costs, damages, or expenses arising from such disclosure and/or refund.

Joint account holder

Your signature: <i>Original Signature Required*</i>	Date:
Name:	(Last four digits of Social Security number ONLY) XXX-XX-
Mailing Address:	Telephone:
City/State/Zip:	Email Address:

Joint account holder

Your signature: <i>Original Signature Required*</i>	Date:
Name:	(Last four digits of Social Security number ONLY) XXX-XX-
Mailing Address:	Telephone:
City/State/Zip:	Email Address:

6. POWER OF ATTORNEY (POA), GUARDIAN OR CONSERVATOR INFORMATION (if applicable)

If you have Power of Attorney, or are Guardian or Conservator of the benefit recipient named in Part 1 on page 1 of this form, and have completed this form on his or her behalf, please complete Part 4 and this section.

My current Power of Attorney, Guardianship or Conservator documentation is (check one):
 On file with the MSERS Attached to this form

Name:	(Last four digits of Social Security number ONLY) XXX-XX-
Mailing Address:	Telephone:
City/State/Zip:	Email Address:

***If including a voided check, please attach. Do not staple.**