



THE COMMONWEALTH OF MASSACHUSETTS

# State Retirement Board

PO BOX 679, WILMINGTON, MA 01887-0679\*

\*For this form only.

Please do not mail anything else to this address. Thank you.

## 2020 BENEFIT VERIFICATION FORM (840 CMR 15.01)

DATA FIELD 2 (NAME)

DATA FIELD 3 (ADDRESS 1)

DATA FIELD 4 (ADDRESS 2)

DATA FIELD 5 (ADDRESS 3)

DATA FIELD 6 (CITY), DATA FIELD 7 (STATE),

DATA FIELD 8 (ZIP CODE)

DATA FIELD 19 (FIRST REQUEST)

**THIS IS AN IMPORTANT FORM**

Failure to fully comply with this request by

DATA FIELD 12

will result in an interruption of your pension benefit. Please see the back for more information.

1

**PLEASE VERIFY THE INFORMATION LISTED BELOW AND RETURN TO THE STATE RETIREMENT BOARD:**

	MEMBER INFORMATION ON FILE	PRINT CORRECTIONS IN SPACE BELOW
Member ID:	DATA FIELD 1	
Name:	DATA FIELD 13	
Address 1:	DATA FIELD 14	
Address 2:	DATA FIELD 15	
Address 3:	DATA FIELD 16	
City:	DATA FIELD 17	
State:	DATA FIELD 18	
ZIP:	DATA FIELD 19	
Phone:	DATA FIELD 9	
Date of Birth:	DATA FIELD 10	
E-mail:	DATA FIELD 11	

2

**THIS SECTION MUST BE SIGNED AND YOUR SIGNATURE WITNESSED**

I hereby certify under the penalties of perjury that the information I have supplied in this form is true, complete and correct to the best of my knowledge and that I continue to be eligible to receive benefits through the State Employees' Retirement System. **Complete Section 4 on the reverse side if you are completing this form on behalf of the benefit recipient.** (Failure to properly, fully and legibly complete this form as instructed will cause the form to be rejected.)

Signature

Date

3

**YOUR SIGNATURE MUST BE WITNESSED BY A THIRD PARTY**

(For 2020 only, the Board is not requiring the notarization of this form. Your signature must be witnessed by someone who is over 18 years of age.)

Printed Name of Witness

Address

City/State/Zip code

Relationship to Retiree/Beneficiary

Signature of Witness

Date

## ► Information for Completing the Benefit Verification Form

Regulation 840 CMR 15.01 requires that each person who receives a benefit from the State Retirement Board ("the Board") regularly file a Benefit Verification Form to certify they are currently living and eligible to receive benefits. Please complete sections 1-3 on the front of the form and return to the Board by the date listed on the front. If you are not the benefit recipient, please also complete section 4. The Board could interrupt your pension benefits if your properly, fully and legibly completed form is not returned.

- **Section 1** has information that the Board has on file for the benefit recipient. Please review the information listed on the left-hand column. If you notice any errors, please print corrections on the space provided on the right. **If you write in a name change you must provide documentation** such as a copy of a marriage certificate or divorce decree. Please do not write in a temporary address change. The space provided is for permanent address changes only.
- **Section 2 must be signed by the benefit recipient before a third-party witness.** If you are not the benefit recipient, please complete section 4 and sign section 4. For 2020 only, the Board is not requiring the notarization of this form. Your witness must be over eighteen years of age.
- **Section 3 must be completed and witnessed by a third party.** If the benefit recipient is deceased, you may skip this section and go to Section 4.
- **Section 4 is not filled out by the benefit recipient.** In the event that a benefit recipient is under guardianship, conservatorship, or has assigned power of attorney\* and the Board does not have the proper and current documents, please attach a copy to this form. If an individual does not have power of attorney, guardianship or conservatorship, and is unable to complete this form, a letter from an attending physician must accompany this form. Please notify the Board in the case of death of a benefit recipient.

**This form must be completed and returned by DATA FIELD 12 (August 7, 2020).**

*Please mail your form in the envelope provided.*

**Failure to properly, fully and legibly complete this form as instructed will cause the form to be rejected.**

4

**Complete this section ONLY if the Benefit Recipient is deceased, or under guardianship or conservatorship, or has assigned power of attorney\* to another person**

**a. The Benefit Recipient named on the front of this form is (check one)**

☐

**Deceased. His or her date of death was:**

Please: Call our office as soon as possible.

Attach a photocopy of the Benefit Recipient's death certificate to this form and return to our office.

☐

**Under guardianship or conservatorship, or has assigned power of attorney\* to another person.**

**Please sign section 2 on the reverse before a third party witness and have the witness complete section 3.**

☐

The document assigning guardianship, conservatorship or power of attorney was previously submitted to the Board and it has not changed or expired. Accordingly, that document is not attached.

☐

Attached is a photocopy of the document assigning guardianship, conservatorship or power of attorney.

**b. Completed by:**

Your Name

Please Print

Your Relationship to

Benefit Recipient:

Your  
Address:

Your Daytime  
Phone Number:

\* Please note that if you have a medical only power of attorney, you are **not** qualified to complete this form.

A **general** or **durable** power of attorney is required to complete this form on behalf of the recipient.

**Mailing address to return form: MSRB, PO Box 679, Wilmington, MA 01887-0679 | Phone: 617-367-7770 | Toll Free (within MA): 1-800-392-6014**  
**mass.gov/retirement**