



THE COMMONWEALTH OF MASSACHUSETTS

State Retirement Board

ONE WINTER ST, 8TH FL, BOSTON, MA 02108

TEL: 617-367-7770 OR TOLL FREE 800-392-6014

2018 BENEFIT VERIFICATION FORM (840 CMR 15.01)

THIS IS AN IMPORTANT FORM

Failure to fully comply with this request
by

JULY 25, 2018

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:		
Name:		
Address 1:		
Address 2:		
Address 3:		
City:		
State:		
ZIP:		
Phone:		
Date of Birth:		
E-mail:		

2 THIS SECTION MUST BE SIGNED AND YOUR SIGNATURE WITNESSED BY A NOTARY PUBLIC.

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. **Complete Section 4** on the reverse side if you are completing this form on behalf of the benefit recipient.

Signature

Date

3 THIS FORM MUST BE NOTARIZED BEFORE RETURNING! SECTION BELOW MUST BE COMPLETED!

_____ (print name) personally appeared, known to me who first being duly sworn, subscribed his/her name before me.

Affix
Notary
Seal or Stamp
Here
(Required)

Signature of Notary Public

Date

Printed Name of Notary Public

My Commission expires

► 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. 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 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 notary public.** If you are not the benefit recipient, please complete section 4 and sign section 4 before a notary public.
- **Section 3 must be completed by a notary public.** Please note that the **notary seal or stamp is a requirement** and must be attached. Any form that is signed by a notary without an accompanying seal/stamp will not be accepted. 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 7/25, 2018.
Please mail your form in the envelope provided.

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 notary public and have notary 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