PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

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:**

PLEASE NOTE: THIS FORM MUST BE NOTARIZED