

# New Member Enrollment Form

Form Last Revised: October, 2001

**Retirement Board:** Please place your address and phone number here. ▶

WORCESTER REGIONAL RETIREMENT SYSTEM  
 23 MIDSTATE DRIVE, SUITE 106  
 MIDSTATE OFFICE PARK  
 AUBURN, MASSACHUSETTS 01501

## Employee Name

Last   
  First   
  M.I.   
  - - Social Security #   
  Sex

## Address

Street and Number   
  City/Town   
  State   
  Zip   
  Phone #

Birth Name or Former Name (if different)   
  Date of Birth\*   
  M   
  S   
  W   
  D Marital Status

Spouse's Name   
  Spouse's Date of Birth   
  # of Children

GRAFTON (SCHOOL) Agency or Department\*\*   
  Title/Position   
  Starting Date of Present Service

\* The retirement board may request a copy of birth records, military discharge papers and other pertinent data.

\*\* For those retiring from regional or county retirement system, please indentify the community.

Are you retired from any other Massachusetts public retirement system?  Yes  No

Were you ever a member of any other Massachusetts public retirement system?  Yes  No

### List prior or current public retirement system membership:

SYSTEM	DATES OF MEMBERSHIP	ARE YOUR FUNDS STILL ON DEPOSIT?
<input type="text"/>	<input type="text"/> to <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/> to <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/> to <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you wish to purchase past creditable service, you must make that request in writing of the relevant retirement system and produce acceptable proof of such service.

Did you ever work for or do you currently work for the Commonwealth or one of its political subdivisions for which you were not/are not a contributing member of a retirement system?  Yes  No



		M.I.	- -
Member's Last Name	First	M.I.	Social Security #

List prior or current employment with the Commonwealth or one of its political subdivisions (Non-membership) :

EMPLOYER	DATES OF EMPLOYMENT
	to
	to
	to

Are you a Veteran?\*  Yes  No Dates of Active Duty Service to

\* The retirement board may request a copy of birth records, military discharge papers and other pertinent data.

I hereby authorize the Treasurer to withhold the proper percent of my regular compensation due on each pay period and to deposit such deductions to my credit in the annuity savings fund. I understand the full amount of such deductions, with regular interest as provided by law, will be returned to me upon my written request if I terminate my service, unless I plan to accept a position which would entitle me to become a member of any other contributory retirement system in the Commonwealth. In the event that I die before retiring, my beneficiary or beneficiaries may receive survivor benefits or a refund of my accumulated total deductions as allowed by law.

I sign this form under the pains and penalties of perjury. I affirm that the information presented in this form is correct, complete and accurately presented. I understand that giving false or incomplete information may subject me to the loss of my benefits as well as civil and criminal penalties.

Employee's Signature \_\_\_\_\_ Date: \_\_\_\_\_

To Be Completed by Payroll/Personnel Department and Verified by Retirement Board:

Check base rate to be deducted for retirement:

5%  7%  8%  9%  Additional 2%

If 5% or 7% or 8%, state reason:

Current Rate of Regular Compensation per Pay Period:

Employment Status (Check all that apply):

Permanent  Temporary  Full-time  Part-time:  50%  75%  Other \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name

To Be Completed by the Retirement Board:

Membership Date \$  Annual Regular Compensation  % to be deducted  
 Group Classification

The member must also complete the Beneficiary Selection Form.

# Beneficiary Selection Form (If Member Dies Before Retirement)

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## Choice of Beneficiary to Receive a Return of Accumulated Total Deductions at Member's Death

I, (Print Name) , a member of the  Retirement System hereby request the Board of Retirement to pay any sum referred to in G.L. c. 32, § 11(2)\* due at my death to the following beneficiary or beneficiaries in the proportions designated.

My selection may be superseded by a selection under G.L. c. 32, § 12(2)(d) if I die leaving an eligible spouse who elects to receive a monthly benefit.

I understand that I may change my beneficiary designation at any time prior to my retirement and that upon my retirement, this form becomes void.

\*The types of payments covered under G.L. c. 32, § 11(2) include:

- The payment of the accumulated deductions credited to a member's account in the annuity savings fund at the date of death when the member's death occurs prior to his/her retirement.
- The amount of any uncashed checks payable to a member at his or her death.
- Any person or entity may be a beneficiary under G.L. c. 32, § 11(2). Give complete name and address of each beneficiary below:

		Proportion To Be Paid
Name	<input type="text"/> SSN <input type="text"/>	<input type="text"/>
Address	<input type="text"/>	
Name	<input type="text"/> SSN <input type="text"/>	<input type="text"/>
Address	<input type="text"/>	
Name	<input type="text"/> SSN <input type="text"/>	<input type="text"/>
Address	<input type="text"/>	
Name	<input type="text"/> SSN <input type="text"/>	<input type="text"/>
Address	<input type="text"/>	

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

Member's Address



<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Member's Last Name	First	M.I.	Social Security #

To Be Completed by Witness of Choice of Beneficiary of Accumulated Total Deductions.

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

Name of Witness (Print) \_\_\_\_\_

Choice of Option (D) Beneficiary

I, (Print Name) , a member of the  Retirement System, hereby nominate the beneficiary \* listed below, under the provisions of G.L. c. 32, § 12(2)(d) to receive from the retirement system a benefit equal to the Option (C) retirement allowance which would otherwise have been payable to me in the event that I die before being retired.

I understand that I may change my beneficiary designation at any time prior to my retirement and that upon my retirement this form becomes void.

I understand that this choice of Option D Beneficiary can be superceded if, at my death, I leave a spouse to whom I have been married for over one year and with whom I am living on the date of my death, or if living apart, for justifiable cause as determined by the Retirement Board.

Beneficiary

<input type="text"/>	<input type="text"/>
Name of Eligible Beneficiary	Beneficiary's Relationship to Member
<input type="text"/>	<input type="text"/>
Beneficiary's Date of Birth (Attach birth record)	Beneficiary's Social Security #

Member

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

<input type="text"/>	<input type="text"/>
Member's Street Address	Member's Social Security #
<input type="text"/>	<input type="text"/>
City/Town	State Zip

To Be Completed by Witness of Choice of Option D Beneficiary

Witness' Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness' Name (Print)

\* An eligible beneficiary is defined under G.L. c. 32, § 12(2)(d) as the spouse, former spouse who has not remarried, child, father, mother, sister or brother of the member.