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*.

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:						
						%

*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:**			