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

Introduction
Beneficiary Selection Form for Refund of Accumulated Deductions
(If Member Dies Before Retirement)
Pursuant to Massachusetts General Laws, Chapter 32, Section 11(2)(c)

Form Last Revised: February, 2020

The *Beneficiary Selection Form for Refund of Accumulated Deductions* allows a member to select a beneficiary or beneficiaries to receive payment of accumulated deductions and other payments due a member if the member dies before retirement, as described at Massachusetts General Laws, Chapter 32, Section 11(2)(c).

The following needs to be kept in mind:

- This form must be filed with the retirement board.
- If you have designated an eligible beneficiary who is alive at the time of your death on the *Beneficiary Selection Form for Option D*, then the money in your annuity account will not be disbursed to anyone in a one-time lump-sum payment, even if you have designated them on this form.
- Any person or entity may be designated as your Refund of Accumulated Deductions beneficiary under Section 11(2)(c). You may designate multiple beneficiaries and must indicate the percentage of the annuity account that you wish each beneficiary to receive. The percentages must total 100%.
- Your selection of a beneficiary on this form also may be superseded by an eligible spouse under the provisions of Option D.
- If your personal situation changes (e.g. divorce, a domestic relations order goes into effect, your beneficiary dies), you should file a new form with your retirement board.
- If you file a new Section 11(2)(c) form with your retirement board, it will supersede any and all prior Section 11(2)(c) forms filed previously by you.
- When you sign this form, it should be witnessed by a disinterested party.
- This form becomes void upon your retirement.

Beneficiary Selection Form for Refund of Accumulated Deductions
(If Member Dies Before Retirement)
Pursuant to Massachusetts General Laws, Chapter 32, Section 11(2)(c)

Retirement Board: Please enter your retirement board information here.

Name of Retirement Board:	DEDHAM RETIREMENT BOARD		
Address:	202 BUSSEY STREET, #101 (Staff@DedhamRET.COM)		
City/Town:	DEDHAM, MA	**Zip Code:**	02026
Telephone:	(781) 326-7693	**Fax:**	(781) 329-4123

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 or Beneficiaries to Receive a Refund of Accumulated Total Deductions at Member's Death:

- Any person or entity may be a beneficiary under Massachusetts General Laws, Chapter 32, Section 11(2)(c). Give complete name and address of each beneficiary on the next page.

I, (Print Name) _____, a member of the _____ Retirement System hereby request the Retirement Board to pay any sum referred to in Massachusetts General Laws, Chapter 32, Section 11(2)(c) due at my death to the following beneficiary or beneficiaries in the proportions designated on the next pages.

Member Last Name:		First Name:		SSN:	***-**-__ __ __ __

PRIMARY LUMP-SUM BENEFICIARY(IES)

Do NOT name any one person or entity as a beneficiary more than ONCE in this section.

Primary Lump-Sum 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.

CONTINGENT LUMP-SUM BENEFICIARY(IES)

In the event that none of the named primary lump-sum beneficiary(ies) above, are alive, or, if an organization, still operating, as of your death.

Contingent Lump-Sum 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.

Beneficiary Selection Form for Refund of Accumulated Deductions

Member Last Name: **First Name:** **SSN:** ***-**-__ __ __ __

I understand that my selection may be superseded if I die with an eligible beneficiary under Option D.

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 Massachusetts General Laws, Chapter 32, Section 11(2)(c) include:

- The one-time 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.
- Any amounts payable to a member at his or her death.

Member's Signature:

Print Name:

Signature: **Date:**

To Be Completed By Witness (should be disinterested party):

Name (Print):

Street Address:

City/Town: **State:** **Zip Code:**

Signature: **Date:**