IntroductionNew Member Enrollment

Form Last Revised: February, 2020

The New Member Enrollment Form allows a newly hired employee to apply for membership in a public retirement system. The form must be completed by any new employee regardless of his or her past employment with any governmental entity. Certain information on this form must be provided by the Payroll/Personnel Department and verified by the retirement board.

A new member must also complete the Beneficiary Selection Form for Refund of Accumulated Deductions and, if applicable, the Beneficiary Selection Form (Option D).

Form Last Revised: February, 2020

Retirement Board: Please enter you	r retirement board info	rmation here.			
Name of Retirement Board:	WORCESTER REGI	ONAL RETIF	REMENT SYS	STEM	
Address:	23 MIDSTATE DRI	VE, SUITE 1	06		
City/Town:	AUBURN, MA		Zip Code: 0	1501	
Telephone:	508-832-6314		Fax: 5	08-832-6318	
Employee Information					
Employee Last Name:	First Name	e:.		M.I.:	
Social Security # (Entire #):	Phone	#:		Sex:	
Street Address:					
City/Town:	Stat	te:	C	Zip Code:	
Birth/Former Name (if different)			Email:		
Date of Birth*:	Marital Stat	us: Single	Married	Widowed	Divorced*
Spouse's Name:	Spouse's DO	B:		# of Children:	
*If Divorced and you have a Qualified If Current/Prior Retirement Syst List prior or current public retirement	tem Membership		se attach a cop	y.	
Are you retired from any other			tem?	☐ YES	Пио
Were you ever a member of an				YES	□ NO
List prior or current public retirement sy	stem membership:				
		DATES OI	F MEMBERSH	IP APE VOI	IR FUNDS
SYSTEM		From:	To:	Figure 1 to 1 t	DEPOSIT?
				YES	□ NO
				YES	NO
				YES	NO
If you wish to purchase past creditable service	ce, please ask your Retirem	ent Board abou	t your options.		
Did you ever work for or do you political subdivisions for which a retirement system?				its YES	□ NO

Other Public Employment in Massachusetts List prior or current public employment in Massachusetts or one of its political subdivisions (Non-membersh DATES OF EMPLOYMEN From: To: Female	Member Last Name:	First Name:	SSN: ***-**
Veteran Status DATES OF ACTIVE SERVICE Are you a veteran? If YES, please enter dates of service and attach a copy of your military discharge papers, Forms DD-214, DD-215, DD-256, NGB 22, or NGB 22A. I hereby authorize the Treasurer to withhold the proper percentage of my regular compensation due on each pay period and deposit such deductions to my credit in the annuity savings fund. I understand the full amount of such deductions, with regular to the regular position which would entitle me to become a member of any other contributory retirement system in the Commonwealth or other conditions apply. In the event that I die before retiring, my named beneficiary or beneficiaries may receive survivor ben OR a refund of my accumulated total deductions as allowed by law. I sign this application under the penalties of perjury. I affirm that the information presented in this application 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. Applicant's Signature:	Other Public Employn	nent in Massachusetts	
Veteran Status DATES OF ACTIVE SERVICE Are you a veteran? If YES, please enter dates of service and attach a copy of your military discharge papers, Forms DD-214, DD-215, DD-256, NGB 22, or NGB 22A. I hereby authorize the Treasurer to withhold the proper percentage of my regular compensation due on each pay period and deposit such deductions to my credit in the annuity savings fund. I understand the full amount of such deductions, with regulancers 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 or other conditions apply. In the event that I die before retiring, my named beneficiary or beneficiaries may receive survivor ben OR a refund of my accumulated total deductions as allowed by law. I sign this application under the penalties of perjury. I affirm that the information presented in this application 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. Applicant's Signature:	List prior or current public	employment in Massachusetts or one	of its political subdivisions (Non-membership):
Veteran Status DATES OF ACTIVE SERVICE Are you a veteran? If YES, please enter dates of service and attach a copy of your military discharge papers, Forms DD-214, DD-215, DD-256, NGB 22, or NGB 22A. I hereby authorize the Treasurer to withhold the proper percentage of my regular compensation due on each pay period and deposit such deductions to my credit in the annuity savings fund. I understand the full amount of such deductions, with regulances the provided by law, will be returned to me upon my written request if I terminate my service, unless plan to accept a position which would entitle me to become a member of any other contributory retirement system in the Commonwealth or other conditions apply. In the event that I die before retiring, my named beneficiary or beneficiaries may receive survivor ben OR a refund of my accumulated total deductions as allowed by law. I sign this application under the penalties of perjury. I affirm that the information presented in this application 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. Applicant's Signature:			DATES OF EMPLOYMENT
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I hereby authorize the Treasurer to withhold the proper percentage of my regular compensation due on each pay period and deposit such deductions to my credit in the annuity savings fund. I understand the full amount of such deductions, with regular expression which would entitle me to become a member of any other contributory retirement system in the Commonwealth or other conditions apply. In the event that I die before retiring, my named beneficiary or beneficiaries may receive survivor ben OR a refund of my accumulated total deductions as allowed by law. I sign this application under the penalties of perjury. I affirm that the information presented in this application 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. Applicant's Signature:			
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I hereby authorize the Treasurer to withhold the proper percentage of my regular compensation due on each pay period and deposit such deductions to my credit in the annuity savings fund. I understand the full amount of such deductions, with regular terest 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 or other conditions apply. In the event that I die before retiring, my named beneficiary or beneficiaries may receive survivor benome a refund of my accumulated total deductions as allowed by law. I sign this application under the penalties of perjury. I affirm that the information presented in this application 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. Applicant's Signature:	military discharge paper		
deposit such deductions to my credit in the annuity savings fund. I understand the full amount of such deductions, with regulaterest 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 or other conditions apply. In the event that I die before retiring, my named beneficiary or beneficiaries may receive survivor ben OR a refund of my accumulated total deductions as allowed by law. I sign this application under the penalties of perjury. I affirm that the information presented in this application 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. Applicant's Signature:			
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Applicant's Signature:	OR a refund of my accumulated I sign this application under the complete and accurately presen	I total deductions as allowed by law. penalties of perjury. I affirm that the information in the informatio	mation presented in this application is correct,
게 많은 이렇게 보고 있는 것이 없는 것이 뭐 같을 하면 했다. 그런 그런 하고 있는데 그리고 있다고 있다고 있는데 가장 하면 이렇게 되었다. 		riminal penalties.	
Print Employee's Name:			
Employee's Signature: Date:			Date:

Member Last Name:	First Name:	SSN: ***_**
	rtment and verified by Retireme	nt Board:
If 5%, 7%, or 8%, state reason:		
Current Rate of Regular Compensation per Pay Peri	iod: \$	
Employment Status (Check ALL that apply):		
Permanent Temporary Full-time	Part-time 50% 7	5% Other:
Agency/Dept:		Title/Position:
Starting Date of Present Position:		
Authorized Signature:		Date:
Print Name:		
Retirement Board		
To be completed by Retirement Board:		
Membership Date:	Annual Regular Compensation	
% to be Deducted	Current Group Classification	•

The member should also complete the *Beneficiary Selection Form (Refund)* or if applicable, the *Beneficiary Selection Form (Option D)*.

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)

Form Last Revised: July, 2019

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Retirement Board: Please enter	your retirement b	oard information here
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Name of Retirement Board: WORCESTER REGIONAL RETIREMENT SYSTEM

Address: 23 MIDSTATE DRIVE, SUITE 106

City/Town: AUBURN, MA

Zip Code: 01501

Telephone: 508-832-6314

Fax: 508-832-6318

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.

(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.

Beneficiary Selection Form for Refund of Accumulated Deductions

M	om	har	Last	Ma	me

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.

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:			

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 Benefi	ciary 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:			
cull 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:			
ull 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.

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION 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	r Option D.
I understand that I may change my ben retirement, this form becomes void.	eficiary designation at any time prior to my retireme	ent and that upon my
The types of payments covered under N	tassachusetts General Laws, Chapter 32, Section 11(2)(c) include:
	accumulated deductions credited to a member's acc n the member's death occurs prior to his/her retiren	
 Any amounts payable to a me 	mber at his or her death.	
Member's Signature:		
Print Name:		
Signature:		Date:
To Be Completed By Witness (si	rould be disinterested party):	
Name (Print):	iodia de districrestea party).	
Street Address:		
City/Town:	State:	Zip Code:
Signature:		Date:

Introduction

Beneficiary Selection Form - Option D (If Member Dies Before Retirement)

Pursuant to Massachusetts General Laws, Chapter 32, Section 12(2)(d)

Form Last Revised: February, 2020

The Beneficiary Selection Form - Option D allows a member to select an eligible beneficiary to receive an allowance if the member dies before retirement. This is the Member Survivor allowance described at Massachusetts General Laws, Chapter 32, Section 12(2)(d) ("Option D").

The following needs to be kept in mind:

- This form must be filed with the retirement board.
- If you designate an eligible beneficiary on this form, and that beneficiary is living at the time of your
 death, the money in your annuity account will not be disbursed to anyone in a one-time, lump-sum
 payment, even if you have named them to receive such money on your Beneficiary Selection Form for
 Refund of Accumulated Deductions.
- You may name only one person as the Option D beneficiary. That one person may be your spouse, your former spouse who is not remarried at the time of your death, your child, your father, your mother, your sister or your brother.
- If you select a beneficiary other than the spouse to whom you are married at the time of your death, your selection on this form may be superseded by the eligible spouse under the provisions of Option D if you die before retirement.
- 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 Option D form with your retirement board, it will supersede any and all prior Option D forms previously filed by you.
- When you sign this form, it should be witnessed by a disinterested party.
- To cancel an Option D beneficiary designation prior to retirement, your written notice must be filed with the retirement board.
- This form becomes void upon your retirement.

Beneficiary Selection Form - Option D (If Member Dies Before Retirement) Pursuant to Massachusetts General Laws, Chapter 32, Section 12(2)(d)

Form Last Revised: July, 2019

Retirement Board: Plea	se enter you	r retirement bo	ard information	n here.	
				RETIREMENT S	YSTEM
	Address:	23 MIDSTATE	E DRIVE, SUI	ΓE 106	
	City/Town:	AUBURN, MA	1	Zip Code:	01501
	Telephone:	508-832-6314		Fax:	508-832-6318
Member's Information	on:				
					***_**_
Member's Last Name		Member's	First Name		Social Security # (last four)
Street Address:					
City/Town:				State:	Zip Code:
Email:					
Phone:					
Choice of Option D B	eneficiary				
I, (Print Name)		, a	member of the		
	(d) to receive for	om the retireme	nt system a bene	efit equal to the Opt	assachusetts General Laws, ion C retirement allowance which
I understand that I may cheform becomes void.	nange my bene	eficiary designation	on at any time p	rior to my retiremen	t and that upon my retirement this
I understand that this cho service and leave a spous or if living apart, doing so	e to whom I ha	ve been married	for over one year	r and with whom I	e at least two years of creditable am living on the date of my death,
Beneficiary					
This person is my:	Paren	t 🗆	Sibling	Unm	arried Former Spouse*
	Spou	se*	Child		
Name of Eligible Benef	iciary:				
Beneficiary's Date of (attach birth Beneficiary's Street Ad	record)		Benefic	ary's Social Securi	ty #:
					m. a. t
City/	Town: *if be	neficiary is your s	State:	spouse, a copy of yo	Zip Code: our marriage certificate is required
Mombor's Signature					
Member's Signature					
	Name:				
Sign	nature:				Date:
To Be Completed By	Witness (sl	nould be disin	terested party	/):	
Print	Name:				
Street Ad	ldress:				
City	Town:			State:	Zip Code:
Sign	ature:			D	ate:

Statement Concerning Your Employment in a Job Not Covered by Social Security

Not C	overed by Social Security	
Employee Name	Employee ID#	_
Employer Name Town of Lancaster	Employer ID# 04-6001194	_
you may receive a pension based on earn from Social Security based on either your wife, your pension may affect the amount	d under Social Security. When you retire, or if you become disable ngs from this job. If you do, and you are also entitled to a benefit own work or the work of your husband or wife, or former husband of the Social Security benefit you receive. Your Medicare benefit ocial Security law, there are two ways your Social Security benefit	t d or s,
Windfall Elimination Provision		
modified formula when you are also entitle As a result, you will receive a lower Social job. For example, if you are age 62 in 201 a result of this provision is \$395.50. This a	our Social Security retirement or disability benefit is figured using to a pension from a job where you did not pay Social Security Security benefit than if you were not entitled to a pension from the state of the maximum monthly reduction in your Social Security benefit mount is updated annually. This provision reduces, but does not fit. For additional information, please refer to Social Security n."	tax. his it as
become entitled will be offset if you also re	vision, any Social Security spouse or widow(er) benefit to which ceive a Federal, State or local government pension based on we The offset reduces the amount of your Social Security spouse or	ork
Security, two-thirds of that amount, \$400, you are eligible for a \$500 widow(er) bene \$400=\$100). Even if your pension is high	of \$600 based on earnings that are not covered under Social is used to offset your Social Security spouse or widow(er) benefit, you will receive \$100 per month from Social Security (\$500 - enough to totally offset your spouse or widow(er) Social Security at age 65. For additional information, please refer to Social Security	,
provision, are available at www.socialsecu	information, including information about exceptions to each rity.gov. You may also call toll free 1-800-772-1213, or for the do 300-325-0778, or contact your local Social Security office.	eaf
	1945 that contains information about the possible effects of Government Pension Offset Provision on my potential futur	
Signature of Employee	Date	