FRANKLIN REGIONAL RETIREMENT SYSTEM

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Beneficiary Designation Form for Retirees and Survivors

For payment of last check of Option A and B Retirees and Survivor Benefit Recipients Only

My Last four SSN# _____

In accordance with the provisions of M.G.L. Chapter 32, §11(2)(c), I,_____, a member of the Franklin Regional Retirement System, hereby nominate the following named beneficiary(ies)* to receive a lump-sum payment of any benefits that I earned in the month of my death that have not been issued to me.

*Charities are allowed.

BENEFICIARY INFORMATION

Name:_____ D.O.B. _____

SSN#: _____ Relationship to Member: _____

Address:_____

City & State: _____ % of Payment:_____

Name:_____ D.O.B. _____

SSN#: _____ Relationship to Member: _____

Address:_____

City & State: _____ % of Payment:_____

See back side of this sheet for additional beneficiaries.

Signature required by the Member and a Witness who is not listed as a beneficiary above

Member Signature (required):_____Date:_____

Member address:_____

Witness Signature (required):_____Date:_____

Witness Printed Name/Address:_____

Types of Payments covered under Section 11(2)(c) include:

If Option (A) or (B) was chosen at the time of retirement, the payment of any prorated monthly amount due at your death.

If Option (B) was chosen at time of retirement, the payment of any cash refund due at your death if listed Option B beneficiary(ies) predeceases retiree/member.

note: use "Option B Beneficiary Change form" to change actual Option B beneficiaries

If you are receiving a Survivor Benefit, the payment of any prorated monthly amount due at your death.

My Last four SSN# _____

In accordance with the provisions of M.G.L. Chapter 32, §11(2)(c), I,_____, a member of the Franklin Regional Retirement System, hereby nominate the following named beneficiary(ies)* to receive a lump-sum payment of any benefits that I earned in the month of my death that have not been issued to me.

*Charities are allowed.

ADDITIONAL BENEFICIARIES' INFORMATION

Name:_____ D.O.B. _____
SSN#: _____ Relationship to Member: _____
Address:_____
City & State: _____ % of Payment:_____

Name:_____ D.O.B. _____
SSN#: _____ Relationship to Member: _____
Address:_____
City & State: _____ % of Payment:_____

Name:_____ D.O.B. _____
SSN#: _____ Relationship to Member: _____
Address:_____
City & State: _____ % of Payment:_____

Name:_____ D.O.B. _____
SSN#: _____ Relationship to Member: _____
Address:_____
City & State: _____ % of Payment:_____

Signature required by the Member and a Witness who is not listed as a beneficiary above

Member Signature (required):_____Date:_____
Member address:_____
Witness Signature (required):_____Date:_____
Witness Printed Name/Address:_____