Introduction
New Member Enrollment Form

Form Last Revised: October, 2001

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 eligible 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 member's beneficiary to receive a refund of the member's total accumulated deductions is now selected on the *Beneficiary Selection Form.*

New Member Enrollment Form

Form Last Revised: October, 2001

Retirement Board: Please place your address and phone number here. ▸	Middlesex County Retirement System 25 Linnell Circle PO Box 160 Billerica, MA 01865

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

Agency or Department** | Title/Position | Starting Date of Present Service

*** The retirement board may request a copy of birth records, miltary 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?
	to	☐ Yes ☐ No
	to	☐ Yes ☐ No
	to	☐ Yes ☐ 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

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, miltary 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.*

MIDDLESEX COUNTY RETIREMENT SYSTEM

SUPPLEMENTAL NEW MEMBER ENROLLMENT FORM

Supplemental Employment Information

Member's Name: _____

Social Security Number: _____

Employer: _____

Department: _____

Hours of Employment Per Week: _____

Covered by Collective Bargaining Agreement: Yes___ No___

Supplemental Contact Information

Work E-mail Address: _____

Home E-mail Address: _____

Work Phone: _____

Cell Phone: _____

Home Phone: _____

Introduction
Beneficiary Selection Form
(If Member Dies Before Retirement)

Form Last Revised: October, 2001

The *Beneficiary Selection Form* allows a member to select an eligible beneficiary to receive an allowance if the member dies before retirement and to select a beneficiary(ies) to receive payment of accumulated deductions and other payments due to a member if the member dies before retirement. Keep in mind:

- Only certain of your relatives qualify as an eligible beneficiary for benefits under G.L. c. 32, § 12(2)(d), but any person or entity can be selected as a beneficiary(ies) for a return of your accumulated total deductions.

- Your selection on this form may be superseded by an eligible spouse under the provisions of G.L. c. 32, § 12(2)(d) if you die before retirement.

- This form becomes void upon your retirement.

- If you divorce or your personal situation changes, you may wish to file a new form with your retirement board.

Beneficiary Selection Form
(If Member Dies Before Retirement)

Form Last Revised: October, 2001

Retirement Board: Please place your address and phone number here. ▸	Middlesex County Retirement Board P.O. Box 160 25 Linnell Circle Billerica, MA 01865

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		SSN		
Address				
Name		SSN		
Address				
Name		SSN		
Address				
Name		SSN		
Address				

Member's Signature _____ Date _____

Member's Address _____

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

Name of Eligible Beneficiary | Beneficiary's Relationship to Member

Beneficiary's Date of Birth *(Attach birth record)* | Beneficiary's Social Security #

Member

Member's Signature _____ Date _____

Member's Street Address | Member's Social Security #

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.

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