Lawrence Retirement Board

RIVERWALK - ENTRY C
354 Merrimack Street, Suite 302
Lawrence, MA 01843

CITY OF LAWRENCE, MASSACHUSETTS
E-Mail: grizzo@cityoflawrence.com
Visit our website: www.Lawrenceretirement.com

PHONE: (978) 620-3570
FAX: (978) 683-5894

WILLIAM BATEMAN *Chairman*
KEVIN LOUGHLIN *Member*
GINA RIZZO, *Member*
THOMAS CUDDY, *Member*
RAMONA CEBALLOS, *Member*

Dear Prospective Member:

Below is a list of items that **must be completed** and returned to our office in order to establish your membership into the Lawrence Retirement System.

1. **Completed Membership Application**
2. **Completed Beneficiary Form**
3. **A Copy of your Birth Certificate**
4. **Form SSA-1945 (Does not apply for members prior to 2005)**
5. **DD2-14 (military discharge papers) - If applicable**

As an employee of the City of Lawrence, M.G. L. Chapter 32, section 3(2)(a)(l) requires you to become a member of the System upon hiring.

Please provide this office with the listed information so that your membership will be complete. If you have any questions, please do not hesitate to contact us at (978) 620-3570.

*** Please note: As of April 2, 2012, any new member of the retirement system has 1 year from their date of membership to apply to purchase prior Commonwealth of Massachusetts service.*

Retirement Board: Please enter your retirement board information here.

Name of Retirement Board:	Lawrence Retirement Board		
Address:	354 Merrimack Street		
City/Town:	Lawrence, MA	**Zip Code:**	01843
Telephone:	(978) 620-3570	**Fax:**	(978) 722-9490

Employee Information

Employee Last Name:		**First Name:.**		**M.I.:**	
Social Security # (Entire #):		**Phone #:**		**Sex:**	
Street Address:					
City/Town:		**State:**		**Zip Code:**	
Birth/Former Name *(if different)*			**Email:**		
Date of Birth*:		**Marital Status:** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced***			
Spouse's Name:		**Spouse's DOB:**		**# of Children:**	

Your Retirement Board will request a copy of birth records, military discharge papers and other pertinent data.
***If Divorced and you have a Qualified Domestic Relations Order (QDRO), please attach a copy.**

Current/Prior Retirement System Membership

List prior or current public retirement system membership:

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?**	
	From:	**To:**		
			☐ **YES**	☐ **NO**
			☐ **YES**	☐ **NO**
			☐ **YES**	☐ **NO**

If you wish to purchase past creditable service, please ask your Retirement Board about your options.

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 a retirement system? ☐ **YES** ☐ **NO**

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

Other Public Employment in Massachusetts

List prior or current public employment in Massachusetts or one of its political subdivisions (Non-membership):

EMPLOYER	DATES OF EMPLOYMENT	
	From:	To:

Veteran Status

Are you a veteran? ☐ YES ☐ NO

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.

DATES OF ACTIVE SERVICE	
From:	To:

I hereby authorize the Treasurer to withhold the proper percentage 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 or other conditions apply. In the event that I die before retiring, my named beneficiary or beneficiaries may receive survivor benefits **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:

Print Employee's Name:

Employee's Signature: **Date:**

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

Payroll/Personnel Department

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%, 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:

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)*.

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:	Lawrence Retirement Board		
Address:	354 Merrimack Street		
City/Town:	Lawrence, MA	**Zip Code:**	01843
Telephone:	(978) 620-3570	**Fax:**	(978) 722-9490

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:**

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

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: Please enter your retirement board information here.

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Telephone:	(978) 620-3570	**Fax:**	(978) 722-9490

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 Option D Beneficiary

I, (Print Name) _____, a member of the _____ Retirement System, hereby nominate the beneficiary listed below, under the provisions of Massachusetts General Laws, Chapter 32, Section 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 have at least two years of creditable service and 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, doing so for justifiable cause as determined by the Retirement Board.

Beneficiary

This person is my: ☐ Parent ☐ Sibling ☐ Unmarried Former Spouse* ☐ Spouse* ☐ Child

Name of Eligible Beneficiary:					
Beneficiary's Date of Birth: *(attach birth record)*		**Beneficiary's Social Security #:**			
Beneficiary's Street Address:					
City/Town:		**State:**		**Zip Code:**	

*If beneficiary is your spouse or former spouse, a copy of your marriage certificate is required

Member's Signature:

Print Name:			
Signature:		**Date:**	

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

Print Name:					
Street Address:					
City/Town:		**State:**		**Zip Code:**	
Signature:		**Date:**			