FRANKLIN REGIONAL RETIREMENT SYSTEM

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Residual 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:____