

# FRANKLIN REGIONAL RETIREMENT SYSTEM

101 MUNSON STREET, SUITE 108 GREENFIELD, MA 01301

TELEPHONE: 413-774-4837

Email: general.frrsma@gmail.com

## 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: \_\_\_\_\_

<b>Signature required by the Member and a Witness who is not listed as a beneficiary above</b>	
Member Signature (required): _____	Date: _____
Member address: _____	
Witness Signature (required): _____	Date: _____
Witness Printed Name/Address: _____	