THE COMMONWEALTH OF MASSACHUSETTS

State Board of Retirement

ONE ASHBURTON PLACE, BOSTON, MA 02108-1607

OPTION SELECTION FORM:

OPTION A

THERE ARE NO SURVIVOR RETIREMENT BENEFITS

I request my pension be paid in accordance with Option A as provided in Section 12, subsection 2 of Chapter 32.

I UNDERSTAND BY CHOOSING THIS OPTION, UPON MY DEATH, I RELINQUISH ALL CLAIMS TO THE TOTAL CONTRIBUTIONS AND THE TOTAL INTEREST THAT HAVE BEEN CREDITED TO MY ACCOUNT. My Designated Beneficiary(ies) listed below will receive only a prorated amount for the number of days I live in the month of my death.

THERE ARE NO SURVIVOR BENEFITS.

BENEFICIARY(IES) INFORMATION (MUST BE COMPLETED)

1	Name:	**Designation:**	**Proportion:**	Date of Birth:
	Street:	☐ Primary	☐ All	Relationship:
	City, State, ZIP:	☐ Contingent	☐ _____ % (Percent)	Beneficiary Social Security Number:
2	Name:	**Designation:**	**Proportion:**	Date of Birth:
	Street:	☐ Primary	☐ All	Relationship:
	City, State, ZIP:	☐ Contingent	☐ _____ % (Percent)	Beneficiary Social Security Number:
3	Name:	**Designation:**	**Proportion:**	Date of Birth:
	Street:	☐ Primary	☐ All	Relationship:
	City, State, ZIP:	☐ Contingent	☐ _____ % (Percent)	Beneficiary Social Security Number:
4	Name:	**Designation:**	**Proportion:**	Date of Birth:
	Street:	☐ Primary	☐ All	Relationship:
	City, State, ZIP:	☐ Contingent	☐ _____ % (Percent)	Beneficiary Social Security Number:
5	Name:	**Designation:**	**Proportion:**	Date of Birth:
	Street:	☐ Primary	☐ All	Relationship:
	City, State, ZIP:	☐ Contingent	☐ _____ % (Percent)	Beneficiary Social Security Number:

MEMBER INFORMATION

(Print Name) _____ (Social Security Number) _____

(Signature) _____ (Date) _____

SIGNATURE OF WITNESS—THIS OPTION FORM MUST BE WITNESSED.

IF THE MEMBER IS MARRIED, THE WITNESS MUST BE THE SPOUSE.

By witnessing this form, I acknowledge that I have read and understand the provisions of this Option:

(Print Name) _____

(Address/City/Town/State/Zip) _____

(Signature) _____ (Date) _____