

Applying to Retire from the MA State Employees' Retirement System (MSERS)

Impact of Retiring from the MA State Employees' Retirement System (MSERS)

The screenshot shows the Human Resources website with a navigation bar. The 'Benefits & Pay' menu is highlighted. Below it, a sidebar lists 'Benefits', 'Payroll', and 'Classification and Compensation'. The main content area shows 'Work-life events' with a mouse cursor pointing to it, and 'Employment and income verifications' below it.

...on benefits
www.umass.edu/hr...

The screenshot shows the 'Retiring and Thinking About Retirement' page. It includes an introductory paragraph about advance preparation for retirement. Below this is a list of topics with expandable/collapsible arrows:

- Thinking About Retirement
- Retirement income
- Applying to Retire from MA State Employees' Retirement System (MSERS)
- Applying to Retire from the Optional Retirement Program (ORP)
- Impact of Retirement on Benefits

On the right side, there is a 'Work-Life Events' sidebar with the following items:

- Birth, Adoption or Placement of a Child in Foster
- Marriage
- Name Change
- Moving / Address Change
- Working Part Time in a Benefited Position
- Leaving Employment Impact on Benefits (Benefited)
- Turning 65, Medicare, and Health Insurance
- Retiring (and thinking about retirement)

At the bottom, a note states: 'If you are retired (drawing a retirement income from the MA State Employees' Retirement System or the MA Optional Retirement program):'

Applying to Retire from the MA State Employees' Retirement System (MSERS)

1. Submit an MSERS retirement application to the MA Retirement Board *within* 120 days prior to retirement with supporting documentation
2. Submit your GIC Status / Change Form 1a hard copy to UMass HR
3. Social Security Administration
 - Medicare application(s)?
 - Windfall Elimination Provision/Government Pension Offset notification?
4. Tax-deferral into (or withdrawal from) 403(b) or 457/SMART Plan

THE COMMONWEALTH OF MASSACHUSETTS
State Retirement Board
 One Winter Street, 8th Floor, Boston, MA 02108

**SUPERANNUATION
 RETIREMENT APPLICATION**
*Please complete all required sections.
 Incomplete applications will delay processing.*

1. MEMBER INFORMATION (required)
 I respectfully request superannuation under the provisions of Section 1 to 28 inclusive of Massachusetts General Laws Chapter 32.

Name: _____ SS#: _____

I wish to retire on: (MM/DD/YYYY) _____ with _____ years and _____ months of service

All Former Names: _____

Date of Birth: (Proof of Birth Required) _____ Are You a Veteran? ☐ No ☐ Yes (include copy of DD-214)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Gender: ☐ M ☐ F

If divorced, are you a party to a Domestic Relations Order? ☐ No ☐ Yes ☐ Don't Know

1. If No, please include a copy of your Divorce Decree & Separation Agreement. 2. If No, please include a copy of your Domestic Relations Order.

MSERS Retirement Application

Requires

1. Proof of your date of birth (photocopy of a birth certificate or unexpired passport)
2. Additional information / documentation for:
Option B: Name, address, social security number and date of birth of each beneficiary.
Option C: Proof of your beneficiary's date of birth & proof of relationship to your beneficiary. Eg, if your Option C beneficiary is your spouse, a copy of your marriage certificate.
3. DD214 (honorable discharge paperwork), if applicable.
This may entitle you to a small increase in annual pension.
4. If you are divorced: copy of divorce decree or Domestic Relations Order.
5. Direct Deposit information (routing and account #s), voided check.
6. Spouse's signature (if applicable).

1. MEMBER INFORMATION (required)

I respectfully request superannuation under the provisions of Section 1 to 28 inclusive of Massachusetts General Laws Chapter 32.

Name: _____ SSN: _____
 I wish to retire on: (MM/DD/YYYY) _____ with _____ years and _____ months of service

All Former Names: _____

Date of Birth: (Proof of Birth Required) _____ Are You a Veteran? ☐ No ☐ Yes (include copy of DD-214)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Gender: ☐ M ☐ F

If divorced, are you a party to a Domestic Relations Order? ☐ No¹ ☐ Yes² ☐ Don't Know

¹If No, please include a copy of your Divorce Absolute & Separation Agreement; ²If Yes, please include a copy of your Domestic Relations Order.

Current or Last Place of State Employment: _____

Position/Title: _____

Retirement Group* (If Known): ☐ 1 ☐ 2 ☐ 3 (State Police only) ☐ 4

*Note: You must submit a separate Application for Group Classification for each Group 2, or Group 4 classification request.

2. CONTACT INFORMATION (required)

Personal Email Address: _____

Present Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Address after Retirement (If Different): _____

City: _____ State: _____ Zip: _____ Effective Date: _____

3. SPOUSE INFORMATION (If Applicable)

Spouse's Name: _____

Spouse's Address (If Different): _____

City: _____ State: _____ Zip: _____

Is Spouse a Retiree of a Massachusetts State, City, Town or County Government? ☐ No ☐ Yes

4. MEMBER SIGNATURE (required - application will NOT be processed without signature)

- All statements on this application are true statements made under the penalties of perjury.
- I understand that **no changes can be made to my retirement** or to my option selection after my retirement date.
- I understand that there are three (3) retirement OPTIONS - A, B, or C - and that if I do not choose an option by completing the Option Selection Form on page 7, I will be automatically retired under OPTION B.
- I understand that any benefits payments issued covering periods after my date of death must be re-paid to the State Retirement Board by the appropriate party or by my estate as applicable, and may be recouped from the account I designate for direct deposit.

Sign Here: **X** *Original Signature Required*

Member Signature

Date

THIS SECTION BOARD USE ONLY

Wet signatures required
 on the Retirement Application.

Digital signatures not accepted.

Some tips:

- What *is* a retirement date?
- Years / months of service
- Retirement Group
 Group 2, 3 or 4 > additional form

Member Name: _____ SS#: _____

5. LIST ALL SERVICE WITH STATE, CITY OR COUNTY GOVERNMENT (required*)

Department or Subdivision:	Start Date:	Date Service Ended:

*use additional sheet if necessary

6. MEMBER QUESTIONNAIRE (required)

a. Are you applying for a termination retirement under Section 10(2)(a) of Chapter 32? ☐ No ☐ Yes
 If YES, please attach a Termination Retirement Allowance Employer Certification Form with this application.
 See additional information on termination retirement in the instructions on page 4.

b. Have you ever been convicted of an offense involving the funds or property of your place of employment? ☐ No ☐ Yes

c. Have you ever been convicted of an offense involving your position while in state service? ☐ No ☐ Yes
 If yes to either of the above, please describe the offense(s): _____

d. Have you ever taken a refund? ☐ No ☐ Yes
 If YES, do you wish to buy back time? ☐ No ☐ Yes

Have you completed a buyback?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have a buyback in progress?	<input type="checkbox"/> No <input type="checkbox"/> Yes

e. Have you ever been on an industrial accident leave? ☐ No ☐ Yes If yes, what years? _____

Some tips:

- Department = UMass Amherst
- Section 10 (additional form)
- Buyback?



THE COMMONWEALTH OF MASSACHUSETTS
State Retirement Board
One Winter Street, 8th Floor, Boston, MA 02108

RETIREMENT OPTION SELECTION FORM

MEMBER NAME: _____

SS#: _____

1. CHOOSE ONE OPTION (required) Read the OPTION PROVISIONS on the following page and then CHECK BOX A, B, OR C.



Option A - 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. If choosing A, please complete sections 2 and 3 on this page. Do not complete section 4.



Option B - LUMP SUM PAYMENT TO BENEFICIARY IN EVENT OF EARLY DEATH

I request my pension be paid in accordance with Option B as provided in Section 12, subsection 2 of Chapter 32. If choosing B, please complete sections 2, 3, and 4 (beneficiary information on following page).



Option C - JOINT SURVIVOR ALLOWANCE

I request my pension be paid in accordance with Option C as provided in Section 12, subsection 2 of Chapter 32. If choosing C, please complete beneficiary information below and sections 2 and 3. Do not complete section 4.

OPTION C BENEFICIARY INFORMATION (required only if choosing option C):

Please do not complete this section if selecting Option B. A copy of the beneficiary's birth certificate and if spouse, a copy of your marriage license is required if Option C is selected and must be included with this application.

Option C Beneficiary: _____

SSN: _____

(Please print)

Gender: ☐ M ☐ F

Date of Birth: _____

Relationship to Member: _____

Address/City/State/Zip: _____

2. MEMBER SIGNATURE (required)

I have read and understand the provisions of Option _____ selected above.

(enter option selection: A, B, or C)

Member Signature: X

Date: _____

3. WITNESS SIGNATURE (required)

If married, the witness must be your spouse. Witness CANNOT be a beneficiary unless the witness is your spouse.

Witness Signature: X

Date: _____

Print Name: _____

Address: _____

Please complete section 4 on following page only if selecting Option B.

THIS SECTION BOARD USE ONLY

Some tips:

- Both check the Option box *and* write the letter below
- Dates next to the signatures must be the same

Member Name:	SS#: _____		
▶ Complete this section ONLY if selecting Option B:			
4. BENEFICIARY(IES) INFORMATION (required if Option B is selected, PLEASE PRINT)			
i. Name:	Designation: <small>(Must check 1 box)</small>	Proportion:* <small>(Must check 1 box)</small>	Beneficiary Social Security #:
Street:	<input type="checkbox"/> Primary OR	<input type="checkbox"/> All, OR	Relationship:
City, State, ZIP:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % <small>(percent)</small>	Date of Birth:
ii. Name:	Designation: <small>(Must check 1 box)</small>	Proportion:* <small>(Must check 1 box)</small>	Beneficiary Social Security #:
Street:	<input type="checkbox"/> Primary OR	<input type="checkbox"/> All, OR	Relationship:
City, State, ZIP:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % <small>(percent)</small>	Date of Birth:
iii. Name:	Designation: <small>(Must check 1 box)</small>	Proportion:* <small>(Must check 1 box)</small>	Beneficiary Social Security #:
Street:	<input type="checkbox"/> Primary OR	<input type="checkbox"/> All, OR	Relationship:
City, State, ZIP:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % <small>(percent)</small>	Date of Birth:
iv. Name:	Designation: <small>(Must check 1 box)</small>	Proportion:* <small>(Must check 1 box)</small>	Beneficiary Social Security #:
Street:	<input type="checkbox"/> Primary OR	<input type="checkbox"/> All, OR	Relationship:
City, State, ZIP:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % <small>(percent)</small>	Date of Birth:
v. Name:	Designation: <small>(Must check 1 box)</small>	Proportion:* <small>(Must check 1 box)</small>	Beneficiary Social Security #:
Street:	<input type="checkbox"/> Primary OR	<input type="checkbox"/> All, OR	Relationship:
City, State, ZIP:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % <small>(percent)</small>	Date of Birth:
* The totals of all proportions for your primary and contingent beneficiary(ies) must equal 100% each.			
OPTION PROVISIONS			
<p>Option A - THERE ARE NO SURVIVOR RETIREMENT BENEFITS As provided in Section 12, subsection 2 of Chapter 32, by selecting this option, upon my death, I relinquish all claims to the total contributions and the total interest that have been credited to my account. I understand my estate will receive only a prorated amount of my monthly allowance for the number of days I live in the month of my death. There are no survivor benefits.</p>			
<p>Option B - LUMP SUM PAYMENT TO BENEFICIARY IN EVENT OF EARLY DEATH As provided in Section 12, subsection 2 of Chapter 32, by selecting this option, I will receive a reduced monthly retirement allowance for life. I also understand that upon my death, if there is a remaining balance in my account - deposits and interest - it will be refunded to my beneficiary(ies) or estate in a lump sum. A prorated amount of my monthly allowance for the number of days I live in the month of my death will go to my estate, unless otherwise determined by the Board. I understand that the annuity portion of my allowance is reduced each month. If my annuity savings account is depleted at the time of my death, I understand that there will be no survivor benefits.</p>			
<p>Option C - JOINT SURVIVOR ALLOWANCE As provided in Section 12, subsection 2 of Chapter 32, by selecting this option, I will receive a reduced retirement allowance for life. I also understand that my named beneficiary will receive two-thirds of my retirement allowance upon my death for his or her lifetime, and I understand should the named beneficiary pre-decease me, my allowance will revert to Option A. An eligible beneficiary may be a spouse, unmarried former spouse (at date of retirement), child, father, mother, brother, or sister. A prorated amount of my monthly allowance for the number of days I live in the month of my death will go to my estate, unless otherwise determined by the Board.</p>			

Some tips:

➤ Only if selecting Option B

Form	W-4P Withholding Certificate for Periodic Pension or Annuity Payments	OMB No. 1545-0074	2023	
Department of the Treasury Internal Revenue Service		Give Form W-4P to the payer of your pension or annuity payments.		
Step 1: Enter Personal Information	(a) First name and middle initial		Last name	(b) Social security number
	Address			
	City or town, state, and ZIP code			
	(c) <input type="checkbox"/> Single or Married filing separately			
	<input type="checkbox"/> Married filing jointly or Qualifying surviving spouse			
<input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)				
Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5. See pages 2 and 3 for more information on each step and how to elect to have no federal income tax withheld (if permitted).				
Step 2: Income From a Job and/or Multiple Pensions/ Annuities (Including a Spouse's Job/ Pension/ Annuity)	Complete this step if you (1) have income from a job or more than one pension/annuity, or (2) are married filing jointly and your spouse receives income from a job or a pension/annuity. See page 2 for examples on how to complete Step 2.			
	Do only one of the following.			
	(a) Reserved for future use.			
	(b) Complete the items below.			
	(i) If you (and/or your spouse) have one or more jobs, then enter the total taxable annual pay from all jobs, plus any income entered on Form W-4, Step 4(a), for the jobs less the deductions entered on Form W-4, Step 4(b), for the jobs. Otherwise, enter "-0-" . . . \$			
(ii) If you (and/or your spouse) have any other pensions/annuities that pay less annually than this one, then enter the total annual taxable payments from all lower-paying pensions/annuities. Otherwise, enter "-0-" . . . \$				
(iii) Add the amounts from items (i) and (ii) and enter the total here . . . \$				
TIP: To be accurate, submit a new Form W-4P for all other pensions/annuities if you haven't updated your withholding since 2021 or this is a new pension/annuity that pays less than the other(s). Submit a new Form W-4 for your job(s) if you have not updated your withholding since 2019. If you have self-employment income, see page 2.				
Complete Steps 3-4(b) on this form only if (b)(i) is blank and this pension/annuity pays the most annually. Otherwise, do not complete Steps 3-4(b) on this form.				
Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):			
	Multiply the number of qualifying children under age 17 by \$2,000		\$	
	Multiply the number of other dependents by \$500		\$	
	Add other credits, such as foreign tax credit and education tax credits		\$	
Add the amounts for qualifying children, other dependents, and other credits and enter the total here			3	\$
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs or pension/annuity payments). If you want tax withheld on other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, taxable social security, and dividends . . .			
	4(a)			\$
	(b) Deductions. If you expect to claim deductions other than the basic standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here			
	4(b)			\$
(c) Extra withholding. Enter any additional tax you want withheld from each payment . . .			4(c)	\$
Step 5: Sign Here				
Your signature (This form is not valid unless you sign it.)			Date	
For Privacy Act and Paperwork Reduction Act Notice, see page 3. Cat. No. 10225T Form W-4P (2023)				

Some tips:

- Can change federal tax withholding at any time



MEMBER NAME: _____

SS#: _____

As you transition into retirement, the State Retirement Board wants to be sure you are aware of the various annual **earnings** limitations if you choose to work in the Massachusetts public sector while receiving your monthly retirement payment. These limitations apply to any public employment, regardless of whether or not it occurs in the same governmental unit or employer from which you retired.

MSERS members who are retired under the various types of superannuation retirement may not earn in a calendar year any amount greater than the difference between the salary currently being paid for the position from which they retired and their pension. Then, after you are retired for one full calendar year (January-December), that dollar amount limit may be increased by an additional \$15,000. Additionally, you also have an annual hourly limit and may not work beyond 1,200 hours in a calendar year.

For example, if the salary for your former position is \$40,000 annually, and your pension is \$20,000 per year, and you have been retired for more than one full calendar year, you may earn up to \$35,000 per calendar year or work up to **1,200 hours, whichever comes first**. ($\$40,000 - \$20,000 = \$20,000 + \$15,000 = \$35,000$). Any excess earnings received must be returned.

IMPORTANT NOTE: Your employment must cease when either limitation is reached, or you may waive the receipt of your retirement allowance. A retiree may not waive the receipt of a retirement allowance to avoid the application of the annual earnings limits. For more information related to the waiver of retirement benefits please contact the State Retirement Board.

In addition to complying with the above limitations, all disability retirees, including those receiving either an accidental or ordinary disability benefit, are required by law (M.G.L. c. 32, §91A) to submit an annual statement of any earnings to the Public Employee Retirement Administration Commission ("PERAC").

For more information related to earnings limits for public retirees working in retirement, please visit PERAC's website: <https://www.mass.gov/guides/working-receiving-a-public-retirement-benefit>.

I (print name), _____ have read the above **Working in Retirement (§91) Acknowledgement** and understand the earnings limitations which would apply if I choose to work in a Massachusetts public sector position while receiving your monthly retirement payment.

X *Original Signature Required*

MSERS Member Signature*

Date

**A computer generated or other non-original signature is not acceptable.*

Post-Retirement Work



1. BENEFIT RECIPIENT (required)

Name:		
Address:		
City:	State:	Zip:
Telephone:	Email Address:	
(Last four digits of Social Security number ONLY) XXX-XX-		MSRB ID # (if known):


2. ACCOUNT INFORMATION (required)

Name of Financial Institution:	
All Names on Account:	
Routing #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Depositor Account #:	
Indicate account type (check one)	ATTACH this required documentation
<input type="checkbox"/> Checking	An original VOIDED check that is imprinted with your name, address, bank name and routing number, and account number. Temporary or starter checks will not be accepted. If you do not have checks personalized with your name and address, you must attach your bank's signed, official account verification document.
<input type="checkbox"/> Savings	Your bank's signed, official account verification document indicating your name, address, bank name and routing number, and account number. A deposit slip will not be accepted.
Indicate account ownership (check one)	
<input type="checkbox"/> Individual:	
<input type="checkbox"/> Joint: (ALL additional joint account holders (other than the Benefit Recipient) MUST complete and sign Part 4 on Page 14.)	
<input type="checkbox"/> I am the benefit recipient's Power of Attorney (POA), Guardian, or Conservator. (You MUST also complete Parts 3 and 5.)	
<input type="checkbox"/> Trust: ATTACH a Certification of Trust that names the benefit recipient as a trustee or a beneficiary of the trust, and check this box. <input type="checkbox"/>	

3. PLEASE SIGN BELOW (required)

"I, _____, hereby authorize the State Treasurer to deposit my retirement benefit into my account at the financial institution named above. The State Treasurer is also authorized to debit or credit my account, to adjust any over deposit which it has caused to be made to my account, and to obtain any nonpublic personal information related to me on record with above financial institution. This authorization will remain in effect until revoked by me with thirty (30) days written notice to the Treasurer and Receiver General, One Winter Street, 8th Floor, Boston, MA 02108, or by the State Treasurer.

I certify that I am the person entitled to receive the payment under this application. I also certify that the information herein provided is accurate to the best of my knowledge."

 _____
 Signature - DO NOT PRINT YOUR NAME
 _____ Date
 *A computer generated or other non-original signature is NOT acceptable.

Some tips:

- Must provide one account (and only one account)
- Can change direct deposit at any time
- Voided check required if depositing into a checking account. (photocopy?)
- UMass direct deposit does *not* carry over automatically to MSERS

MA PayInfo system is Commonwealth's equivalent of HR Direct.



PLEASE COMPLETE PART 4 AND 5 BELOW (if applicable)

4. JOINT ACCOUNT HOLDERS' INFORMATION AND CERTIFICATION (if applicable)

If your payment is being deposited to a JOINT account, Part 4 must be completed and signed by ALL other account holders.
If there are more than two other account holders, attach additional copies of Part 4.

By signing below, and as a party to this account, I understand that I am personally liable, both individually and as a member of the group of parties to this account, to the Massachusetts State Employees' Retirement System (MSERS), which has the legal obligation to recover any overpayment, for the repayment of any monies deposited to this account to which the benefit recipient named on page 13 is not legally entitled. If I am entitled to any benefit from the MSERS as a beneficiary of the benefit recipient, the amount of my liability may be deducted from the amount payable to me. I agree that the financial institution shall have the right of offset for such a refund and I authorize the financial institution to provide the MSERS with my home address. I release the MSERS, the financial institution, and their respective employees, from any and all liability, costs, damages, or expenses arising from such disclosure and/or refund.

Joint account holder

Your signature: <i>Original Signature Required*</i>	Date:
Name:	(Last four digits of Social Security number ONLY) XXX-XX-
Mailing Address:	Telephone:
City/State/Zip:	Email Address:

Joint account holder

Your signature: <i>Original Signature Required*</i>	Date:
Name:	(Last four digits of Social Security number ONLY) XXX-XX-
Mailing Address:	Telephone:
City/State/Zip:	Email Address:

5. POWER OF ATTORNEY (POA), GUARDIAN OR CONSERVATOR INFORMATION (if applicable)

If you have Power of Attorney, or are Guardian or Conservator of the benefit recipient named in Part 1 on page 13 of this form, and have completed this form on his or her behalf, please complete Part 3 and this section.

My current Power of Attorney, Guardianship or Conservator documentation is (check one):

☐ On file with the MSERS ☐ Attached to this form

Name:	(Last four digits of Social Security number ONLY) XXX-XX-
Mailing Address:	Telephone:
City/State/Zip:	Email Address:

*If including a voided check, please attach. Do not staple.

New form required if the pension will be deposited into a joint bank account!

Signature of all joint account holder(s) required.

The MSRB requires this authorization for retirees of the Massachusetts State Employees' Retirement System (MSERS) who wish to submit or change account information electronically (by email; facsimile).

MEMBER INFORMATION (required)

Legal Name:		
Mailing Address:		
City:	State:	Zip:
Personal Email:	Telephone:	
SS# or MSRB ID#:		

PLEASE CHECK THE BOX NEXT TO THE INFORMATION YOU WILL FILE ELECTRONICALLY (required)

☐ Change of Address

Or
 "none"

PLEASE SIGN BELOW (required)

I am authorized to sign the document as a member of the MSERS or on behalf of the member. Under penalties of perjury, I declare that I have examined this document including any accompanying statements, and to the best of my knowledge and belief, it is true, correct, and complete.

 Name

 Date

X

Original Signature Required

Signature*

**A computer generated or other non-original signature is not acceptable.*

THIS SECTION BOARD USE ONLY

Some tips:

- Providing yourself permission to change your address with the Retirement Board via e-mail or facsimile in the future.
- Can change this election in the future by completing and submitting a new form to the Board.

EMPLOYMENT STATUS CHANGE (FORM-1A)

Leave of Absence, Transfers and Termination, Retirement



INSURED INFORMATION			
Insured Information	GIC-ID (usually Soc. Sec. #)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
	Name - Last		Dept. ID # or Agency/Division # UMS / 0147
Address	Street		City State Zip
	Country (if not USA)		
Contact Information	Preferred Phone ()	Preferred Email	
Employment Information	Bargaining Unit/Union Name	HR/CMS or UMASS Employee ID #	Number of work hours/week: / /
Date of Hire / /			
LEAVE OF ABSENCE			
Effective Date (for GIC use only) / 01 /			
Select One: <input type="checkbox"/> Leave with pay <input type="checkbox"/> Leave without pay		Cancel Coverage: <input type="checkbox"/> Basic Life Insurance (if not enrolled in health insurance) <input type="checkbox"/> Basic Life and Health Insurance <input type="checkbox"/> Health Insurance <input type="checkbox"/> Long Term Disability (LTD) <input type="checkbox"/> Optional Life Insurance <input type="checkbox"/> GIC Dental/Vision	
Select Type of Leave:		Leave Start Date: / /	
<input type="checkbox"/> Personal Illness <input type="checkbox"/> Personal Reason <input type="checkbox"/> Military <input type="checkbox"/> Other		Leave End Date: / /	
<input type="checkbox"/> Industrial Accident <input type="checkbox"/> Educational <input type="checkbox"/> Military Caregiver (26 weeks)		Last Day on Payroll: / /	
<input type="checkbox"/> FMLA (12 weeks) <input type="checkbox"/> Substantial <input type="checkbox"/> FMLA Military Exigency (12 weeks)		Return from Leave Date: / /	
<input type="checkbox"/> Maternity <input type="checkbox"/> Suspension <input type="checkbox"/> PFML			
TRANSFERS AND TERMINATION			
Effective Date (for GIC use only) / 01 /			
Transfer from	Name of Agency/GIC Municipality	Last Day of Work: / /	
Transfer to	Name of Agency/GIC Municipality	Hire Date: / /	
Termination of Service Coverage (if elected)	Termination reason	Last Day of Work: / /	
<input type="checkbox"/> 39-week Layoff <input type="checkbox"/> Deferred Retiree (Life only) (See reverse) <input type="checkbox"/> Deferred Retiree (Life & Health) (See reverse) <input type="checkbox"/> COBRA (must complete application) <input type="checkbox"/> Conversion (contact carrier for application)			
RETIREMENT			
Date Retired: / /	Effective Date (for GIC use only) / 01 /		
Health Insurance Election (If enrolling in GIC benefits for the first time, also complete Form-RS) <input type="checkbox"/> Cancel Health Insurance			
Medicare Eligibility - check if applicable: <input type="checkbox"/> Insured <input type="checkbox"/> Spouse Medicare plan election form will be mailed to eligible members.			
Non-Medicare Plan Election for insured or spouse not eligible for Medicare: <input type="checkbox"/> Keep current health plan <input type="checkbox"/> Change Non-Medicare Plan election to Plan name: / /			
Optional Life Insurance Election			
<input type="checkbox"/> Cancel Optional Life <input type="checkbox"/> Reduce Optional Life to Fixed Amount \$ / <input type="checkbox"/> Keep current Optional Life coverage			
<input type="checkbox"/> Reduce Optional Life multiple of salary to: <input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> 4X <input type="checkbox"/> 5X <input type="checkbox"/> 6X <input type="checkbox"/> 7X			
GIC Retiree Dental			
<input type="checkbox"/> I wish to enroll in GIC Retiree Dental and have attached the completed GIC Retiree Dental Enrollment and Change Form located on mass.gov/info-detail/gic-forms .			
<input type="checkbox"/> I do not wish to enroll in the GIC Retiree Dental at this time			
AUTHORIZATION			
I have read the instructions on the reverse side of this form and authorize my employer, or direct my pension authority, to deduct from my payroll or pension check the amount required for the coverage I have selected. I understand that due to IRS regulations, my health insurance coverage elections are binding for the duration of the plan year and that I may only enroll in health insurance or change my coverage elections during the plan year if I experience a qualifying status change (examples include marriage, adoption/birth of a child, death of a dependent, and involuntary loss of other coverage). I understand that the GIC must receive any required documentation within 60 days of the event. You must notify the GIC of a legal separation, divorce or remarriage of you or your former spouse; coverage for a former spouse ends upon remarriage. Failure to notify the GIC can result in financial liability to you.			
Signature of Applicant: / /		Date: / /	
Signature of Authorized Official: / /		Date: / /	

Some tips:

- Please submitted via hard copy to UMass Amherst HR 325 Whitmore Administration Building
- Agency/Division UMS/0147
- Retirement date
- Health insurance election
- Optional Life insurance
- GIC Retiree Dental (additional enrollment form)

Retiring? (you may want to use this as a checklist to track what you've completed)

1. File MSERS retirement application with the MA State Retirement Board
2. File GIC Status Change Form / Form 1a with the GIC or UMass HR
3. Send one-time 403(b) and/or 457 SMART plan deferral forms to UM System Office (if desired)
4. Contact the Social Security Administration (if applicable)
 - Medicare application
 - Notification of retirement for WEP / GPO if you are drawing Social Security income
5. Watch for:
 - Group Insurance Commission/GIC invoices
 - Retirement Board
 - Confirmation of retirement application receipt
 - Annual tax form – 1099R
 - Notary public mailings (fraud prevention mailings)
 - Dental COBRA form

Contact Information

UMassAmherst

Massachusetts State Board of Retirement

www.mass.gov/treasury/retirement/

srb@tre.state.ma.us

One Winter Street

Boston, MA 02108

617.367.7770

Hours: 8:00 a.m. to 4:00 p.m.

Toll Free within MA only (800) 392.6014

436 Dwight Street, Rm 109A

Springfield, MA 01103

413-730-6135

Hours: 8:00 a.m. to 5:00 p.m.

Massachusetts Group Insurance Commission

www.mass.gov/gic, 617.727.2310

Social Security Administration

www.ssa.gov, 1-800-772-1213

Holyoke Social Security Office

200 High Street, Holyoke, MA 01040; 877.480.4989

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UMassAmherst
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