***********2002 EARLY RETIREMENT INCENTIVE PROGRAM***********

ELIGIBILITY REQUIREMENTS

- ALL 5% AND 7% MEMBERS ARE ELIGIBLE FOR THE 2002 EARLY RETIREMENT INCENTIVE PROGRAM.

- AN ADDITIONAL 6,700 MEMBERS WILL QUALIFY BASED UPON YEARS OF CREDITABLE SERVICE.

- YOU MUST HAVE AT LEAST 20 YEARS OF CREDITABLE SERVICE AT ANY AGE OR 10 YEARS OF CREDITABLE SERVICE AND 55 YEARS OF AGE AT DATE OF RETIREMENT.

- ELIGIBLE GROUP ONE MEMBERS WILL APPLY BETWEEN JANUARY 2, 2002 AND FEBRUARY 15, 2002 WITH A RETIREMENT DATE OF MARCH 15, 2002.

- SOME HIGHER EDUCATION EMPLOYEES WILL APPLY BETWEEN JANUARY 2, 2002 AND FEBRUARY 15, 2002 WITH A RETIREMENT DATE OF JUNE 15, 2002.

- COMPLETED APPLICATIONS SHOULD BE MAILED TO STATE BOARD OF RETIREMENT, P.O. BOX 189, BOSTON, MA 02133.

*********2002 EARLY RETIREMENT INCENTIVE PROGRAM*********

RETURN APPLICATION TO:

INFORMATION SHEET

State Board of Retirement, P.O. Box 189, Boston, MA 02133

ELIBILITY REQUIREMENTS:

- 20 years of creditable service at any age or 10 years of creditable service and 55 years of age or older by retirement date.
- Group One employees including higher education, except for Elected officials and those who are paid through federal, trust, or capital accounts.
- Eligible employees will apply between January 1, 2002 and February 15, 2002, with a retirement date of March 15, 2002. Some Higher Education employees will have a retirement date of June 15, 2002.
- Completed Application, including Counseling and Sick and Vacation Payment Consent Form. **A member will be ineligible for the Retirement Incentive if the Sick and Vacation Payment Consent Form is not included in the Application.**

MANDATORY EARLY RETIREMENT INCENTIVE APPLICATION:
RETURN APPLICATION TO: **State Board of Retirement, P.O. Box 189, Boston, MA 02133**

- A fully completed application; on line two please enter actual service.
  (DO NOT INCLUDE INCENTIVE)
- Option Selection Form A, B, or C. If married, a spouse must witness Option Selection Form. **By witnessing the Option, the spouse is confirming he or she understands the Option selection**.
- W-4P Federal Tax Withholding Form indicating option for federal income tax purposes.
- Copy of birth certificate.
- Copy of Veteran's DD 214, if applicable.
- If member is taking Option C a copy of beneficiary's birth certificate and a copy of marriage certificate, if the spouse is the beneficiary, are necessary. If the beneficiary is a former spouse, the spouse must be unmarried on the date of the member's retirement.
- Completed Sick and Vacation Payment Consent and Counseling Form.

BENEFITS:

- The incentive provides an additional five (5) years of creditable service, or of age, or some combination of the two, not to exceed five for any eligible member.

THINGS TO REMEMBER:

- Due to anticipated volume of Retirement Applications, it is very likely you will not receive your first pension check until ninety (90) days from your retirement date.

COUNSELING:

- Counseling will be available at the State Board of Retirement Office, One Ashburton Place, Room 1219 or by phone at (617) 367-7770, extension 1, or 1-800-392-6014 (IN-STATE).

***********STATE BOARD OF RETIREMENT***********

Return Application To: P.O. Box 189, Boston, MA 02133

Phone: (617) 367-7770 or 1 (800) 392-6014 (In-State)

2002 EARLY RETIREMENT APPLICATION

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

SOC. SEC. NO.:__________________________________ I WISH TO RETIRE ON:___________________________________

ACTUAL YEARS OF CREDITABLE SERVICE: _______________YEARS ________________ MONTHS
(DO NOT INCLUDE INCENTIVE)

NAME: ____ MAIDEN NAME: ___________________________________

PRESENT
ADDRESS:____
Street City State Zip

MARRIED? ______ Yes ______ No SPOUSE'S NAME, IF DIFFERENT:____

SPOUSE'S ADDRESS, IF DIFFERENT: ____
Street City State Zip

ADDRESS AFTER RETIREMENT: ____
Street City State Zip

HOME PHONE: (______)_____________________________ WORK PHONE: (______)____________________________

SEX: _____ M _____F DATE OF BIRTH: (BIRTH CERTIFICATE REQUIRED):_______________________________

VETERAN (DD 214): ________ Yes ________ No

AGENCY EMPLOYED BY:_________________________________ POSITION:_____________________________________

RETIREMENT GROUP, IF KNOWN: __________ Group 1

HAVE YOU EVER TAKEN A REFUND? __________ Yes ________ No

IF YES, DO YOU WISH TO BUY BACK YOUR TIME? ____________ Yes __________ No

HAVE YOU EVER BEEN ON INDUSTRIAL ACCIDENT LEAVE? __________ Yes _________ No

IF YES, WHAT YEARS? ____

COLLECTIVE BARGAINING UNIT:____

2002 EARLY RETIREMENT APPLICATION (continued)

LIST ALL SERVICE WITH STATE, CITY OR COUNTY GOVERNMENT.

DEPARTMENT OR SUBDIVISION	START DATE	DATE SERVICE ENDED

THE ABOVE IS A TRUE STATEMENT MADE UNDER THE PENALTIES OF PERJURY. I UNDERSTAND THAT THERE ARE THREE (3) OPTIONS A, B, OR C AND THAT IF I DO NOT PROVIDE A PROPERLY COMPLETED OPTION SELECTION FORM, I WILL BE AWARDED OPTION B.

____ ____________________________________

SIGNATURE **DATE**

IF A W-4P FEDERAL INCOME TAX WITHHOLDING STATEMENT IS NOT FILED, FEDERAL INCOME TAX WITHHOLDING WILL BE CALCULATED AS IF THE RETIREE IS MARRIED WITH THREE (3) EXEMPTIONS.

A RETIREE MAY RETAIN HEALTH INSURANCE AND LIFE INSURANCE AFTER RETIREMENT. CONTACT YOUR PAYROLL DEPARTMENT FOR FURTHER INFORMATION.

*********OPTION SELECTION FORM*********

OPTION A

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.

PLEASE INDICATE BELOW YOUR DESIGINATED PRIMARY BENEFICIARY(IES)

PRIMARY BENEFICIARY INFORMATION (MUST BE COMPLETED)

PROPORTION

NAME:________________________________ SS# ___________________________ ___________%

ADDRESS:____

NAME:________________________________ SS# ___________________________ ___________%

ADDRESS:____

TO ADD MORE PRIMARY BENEFICIARIES OR TO ADD CONTINGENT BENEFICIARY(IES), USE REVERSE SIDE

MEMBER INFORMATION

PRINT NAME:________________________________ SOC. SEC. NO.:__________________

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:________________________________ SOC. SEC. NO.:____________________

ADDRESS:____

SIGNATURE:____ DATE:________________

*********OPTION SELECTION FORM*********

OPTION A (continued)

PLEASE INDICATE BELOW YOUR DESIGNATED BENEFICIARY(IES) AND CONTINGENT BENEFICIARY(IES):

BENEFICIARY INFORMATION (MUST BE COMPLETED

PROPORTION

NAME: ____________________ **SS#** ____________________ **%**

ADDRESS: ____

NAME: ____________________ **SS#** ____________________ **%**

ADDRESS: ____

NAME: ____________________ **SS#** ____________________ **%**

ADDRESS: ____

***********OPTION SELECTION FORM***********

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.

I UNDERSTAND BY CHOOSING 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. THE DESIGNATED BENEFICIARY (IES) WILL RECEIVE A PRORATED AMOUNT FOR THE NUMBER OF DAYS I LIVE IN THE MONTH OF MY DEATH. 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 PAYMENT.

PLEASE INDICATE BELOW YOUR DESIGNATED BENEFICIARY (IES):

BENEFICIARY INFORMATION (MUST BE COMPLETED)

PROPORTION:

NAME: ____________________ SS# ____________ __________%

ADDRESS: ________________________________

NAME: ____________________ SS# ____________ __________%

ADDRESS: ________________________________

TO ADD MORE BENEFICIARIES AND CONTINGENT BENEFICIARY (IES) USE REVERSE SIDE OF THIS FORM.

MEMBER INFORMATION

PRINT NAME: ____________________ SS#.:____________

SIGNATURE: ____________________ DATE: ____________

SIGNATURE OF WITNESS - THIS OPTION FORM MUST BE WITNESSED. IF 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:____________________ SS#.:____________

ADDRESS:________________________________

SIGNATURE:____________ ____________________

*********OPTION SELECTION FORM*********

OPTION B (continued)

PLEASE INDICATE BELOW YOUR DESIGNATED BENEFICIARY (IES) and CONTINGENT BENEFICIARY (IES):

BENEFICIARY INFORMATION (MUST BE COMPLETED)

PROPORTION:

NAME: ______________________________ SS# ______________ __________%

ADDRESS: ____

NAME: ______________________________ SS# ______________ __________%

ADDRESS: ____

NAME: ______________________________ SS# ______________ __________%

ADDRESS: ____

*********<u>OPTION SELECTION FORM</u>*********

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.

I UNDERSTAND BY CHOOSING 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, FORMER SPOUSE (unmarried at date of retirement), CHILD, FATHER, MOTHER, BROTHER, OR SISTER.

<u>BENEFICIARY INFORMATION (PLEASE PRINT)</u>

NAME OF BENEFICIARY: ____

DATE OF BIRTH:__________________________________ **SOC. SEC. NO.:**___________________

RELATION TO MEMBER: _______________________________**SEX:**_______________________

BIRTH CERTIFICATE OF BENEFICIARY IS NECESSARY ALSO A MARRIAGE CERTIFICATE IF BENEFICIARY IS SPOUSE

<u>MEMBER INFORMATION</u>

PRINT NAME:__________________________________ **SOC. SEC. NO.:**___________________

SIGNATURE:____ **DATE:**_______________

<u>SIGNATURE OF WITNESS</u>- THIS OPTION FORM <u>MUST</u> 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:_________________________________ **SOC. SEC. NO.:**_____________________

ADDRESS:____

SIGNATURE:____**DATE:**_______________

***********2002 Early Retirement Incentive Program***********
Sick and Vacation Payment Consent Form

I understand and agree to receive my sick and vacation time, in accordance with general law, to be paid out in three installments:

1/3 on July 1, 2002
1/3 on July 1, 2003
1/3 on July 1, 2004

I further understand that without signing this consent form as part of my retirement application, I am ineligible to participate in the 2002 Early Retirement Incentive Program.

Name ____

(please print)

Social Security Number ____

Address____

____

Agency Employed By ____

Signature____

COUNSELING CONSENT

I understand Counseling will be provided upon my request and that I will be receiving a written estimate of benefits. **PLEASE CHECK APPROPRIATE LINE:**

___________ I Received Counseling.

___________ I Do Not Want Counseling.

SIGNATURE:____

A member will be ineligible for the Retirement Incentive if the Sick and Vacation Payment Consent Form is not included in the Application.

***********2002 EARLY RETIREMENT INCENTIVE PROGRAM***********
BUY BACK REQUEST

PLEASE COMPLETE THIS FORM TO BUY BACK TIME

Name____

Social Sec. #____

Home Address____

Employing Agency____

Start Date with Current Agency ______________________________________

Maiden Name/Other Name used during prior Employment ______________________

****

SERVICE TO BUY BACK

EMPLOYING AGENCY	DATES OF SERVICE	WAS SERVICE REFUNDED?
____________________	____________________	_______________
____________________	____________________	_______________
____________________	____________________	_______________
____________________	____________________	_______________
____________________	____________________	_______________
____________________	____________________	_______________
____________________	____________________	_______________

Original Start Date with the State ____________________

***********THE COMMONWEALTH OF MASSACHUSETTS***********

STATE BOARD OF RETIREMENT

EARLY RETIREMENT INCENTIVE

RETIREE'S WITHHOLDING PREFERENCE CERTIFICATE
2002 FORM W-4P

NAME: ____ **DATE:** ______________________________

ADDRESS: _____________________________________ **SOC. SEC. #:**__________________________

____

____________________________________ **REF. #:**______________________________

(IF KNOWN)

<u>PLEASE CHECK THE APPROPRIATE BOX:</u>

1. **I do not wish to have federal tax withheld from my benefit. I realize that I am liable for payment of federal income tax on the taxable portion of my pension and that I may be subject to pay penalties under the estimated tax payment rules if my payments of estimated tax and withholding are not adequate.**

2. **The following exemptions are being claimed and I wish to have the Plan Administrator determine the amount, if any, of federal income tax to be withheld in accordance with the tax tables and exemptions claimed below.**

   Marital Status:

   __________ **Single** __________ **Married** _____________**Married, but withhold at higher single rate**

   Total exemption(s) you wish to claim: ____________

3. **I wish to have $** ________________ **per month withheld.**

SIGNATURE OF RETIREE:___________________________________ **DATE:** ___________________