Employees' Retirement System of Rhode Island

BENEFICIARY DESIGNATION

Complete all applicable items on this form; incomplete and unsigned forms will be returned.
For additional information, see instructions at the end.

Please print clearly in black ink.

Section 1 – Member information

First and middle names | Last name

Date of birth (*mm/dd/yyyy*) | Social Security number (*4 last digits only*) | ☐ Member ☐ Retiree — Membership status (*check only one*)

Section 2 – Beneficiary designation for other benefits

To name an OAP beneficiary, you must be an active member with at least ten years of contributory service on or before June 30, 2012 or at least five years of contributory service on or after July 1, 2012.

Person as a beneficiary

First name | MI | Last name

Address (*street number, street name and apartment number*)

City | State | Zip code | Telephone (*area code and number*)

Relationship | Social Security number | Date of birth (*mm/dd/yyyy*)

☐ Primary ☐ Contingent — Beneficiary type (*check only one*) | ☐ OAP — OAP election (*if vested*) | ☐ Refund ☐ Death benefit — Benefit type

First name | MI | Last name

Address (*street number, street name and apartment number*)

City | State | Zip code | Telephone (*area code and number*)

Relationship | Social Security number | Date of birth (*mm/dd/yyyy*)

☐ Primary ☐ Contingent — Beneficiary type (*check only one*) | ☐ OAP — OAP election (*if vested*) | ☐ Refund ☐ Death benefit — Benefit type

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Person as a beneficiary (*continued*)

First name | MI | Last name

Address (*street number, street name and apartment number*)

City | State | Zip code | Telephone (*area code and number*)

Relationship | Social Security number | Date of birth (*mm/dd/yyyy*)

☐ Primary ☐ Contingent | ☐ OAP | ☐ Refund ☐ Death benefit

Beneficiary type (*check only one*) | OAP election (*if vested*) | Benefit type

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First name | MI | Last name

Address (*street number, street name and apartment number*)

City | State | Zip code | Telephone (*area code and number*)

Relationship | Social Security number | Date of birth (*mm/dd/yyyy*)

☐ Primary ☐ Contingent | ☐ OAP | ☐ Refund ☐ Death benefit

Beneficiary type (*check only one*) | OAP election (*if vested*) | Benefit type

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First name | MI | Last name

Address (*street number, street name and apartment number*)

City | State | Zip code | Telephone (*area code and number*)

Relationship | Social Security number | Date of birth (*mm/dd/yyyy*)

☐ Primary ☐ Contingent | ☐ OAP | ☐ Refund ☐ Death benefit

Beneficiary type (*check only one*) | OAP election (*if vested*) | Benefit type

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Organization as a beneficiary

Organization name

Address (*street number and name*)

City | State | Zip code | Telephone (*area code and number*)

☐ Primary ☐ Contingent — Benefit category (*check only one*)

☐ Refund ☐ Death benefit — Benefit type

Organization tax ID #

Section 3 – Family information (*to be completed by Judges, Teachers with TSB, State Police, and Police and Fire members only*)

Please make a copy of this page if additional space for family information is needed. Indicating family members below ***does not*** *designate beneficiary status.*

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Current marital status (*check only one*)

Spouse's information

Name | Social Security number | Date of birth (*mm/dd/yyyy*)

Dependent children's information

Name | Social Security number | Date of birth (*mm/dd/yyyy*)

Name | Social Security number | Date of birth (*mm/dd/yyyy*)

Name | Social Security number | Date of birth (*mm/dd/yyyy*)

Name | Social Security number | Date of birth (*mm/dd/yyyy*)

Name | Social Security number | Date of birth (*mm/dd/yyyy*)

Parent's information

Name | Social Security number | Date of birth (*mm/dd/yyyy*)

Name | Social Security number | Date of birth (*mm/dd/yyyy*)

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Section 4 – Member/retiree authorization (*signature must be notarized*)

I, the undersigned, certify that I have read and that I understand the information regarding beneficiary designation available to me as a member or retiree of the Employees' Retirement System of Rhode Island.

Member/retiree signature

M M D D Y Y Y Y
Date of signature

Notarization of member's/retiree's signature (*required*)

State

County

Subscribed and sworn to (or affirmed) before me on the _____ day of _____, 20_____.

Notary public signature

(SEAL)

Notary name (*print*)

M M D D Y Y Y Y
Date of Commission expiration

Notary phone number (*area code and number*)

Please forward this completed form, dated and signed, to the following address:

Employees' Retirement System of Rhode Island
50 Service Avenue 2nd Floor
Warwick, RI 02886-1021
Office: (401) 462-7600 | Fax: (401) 462-7691
Email: ersri@ersri.org | Web site: www.ersri.org