

E _____

G _____
Last 4 Digits of SSN Employee Identification Number

RETIREEE DESIGNATION OF BENEFICIARY

You may submit this form via email to brespon@bers.nyc.gov.
You may also submit this form via fax to (718) 935-4124 or (718) 935-3830.

Prefix

Mr Mrs Ms Miss Other _____

Name M.I. Last Name

Gender Date of Birth

MM / DD / YYYY

Marital Status
 Single Married Divorced Widowed Other _____

OFFICIAL DATE OF RECEIPT

Home/Legal Address Apt. No.

City State Zip Code

Please select the appropriate box for the above address.

Check one: Permanent Address Temporary Address

Important: If you select the Permanent Address box, you are authorizing BERS to use the address on this form to update your records.

Mailing Address (if different from above) Apt. No.

City State Zip Code

Primary Telephone Number Secondary Telephone Number

Is this a Cell # Is this a Cell #
 Yes No Yes No

REQUIRED - Primary Email Address Secondary Email Address

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Board of Education Retirement System

65 COURT STREET
BROOKLYN, NEW YORK 11201-4965

To be valid this form must be filed with the Board of Education Retirement System.

BENEFICIARY DESIGNATION

This designation supersedes all previously filed designation of beneficiary selection filed under the Regular Program, and governs only the payment of benefits thereunder.

In accordance with the rules and regulations governing the Board of Education Retirement System, I hereby authorize BERS to cancel any previous beneficiary designation made by me with regard to the following benefit and nominate the beneficiary(ies) named herein to receive such benefits. I reserve the right to change, in a manner prescribed by the Board, any beneficiary designated herein.

Should I fail to execute this form properly my previous designation of beneficiary will remain in full force and effect. Payment of any benefit will be designated according to the last designation which was properly executed, and if no previous designation was filed, payment of any benefit due will be made to my estate.

DO NOT SIGN OR DATE UNLESS IN FRONT OF A NOTARY

Signature: _____

Date: _____

State of _____ County of _____

On this _____ day of _____ in the year 20 _____

personally appeared before me the said _____

to me known to be the individual described in and who executed the

foregoing document, and he (she) duly acknowledged to me that he

(she) executed the same, and the statements contained therein are true.

Signature of Notary Public or Commissioner of Deeds

Affix official seal in the box below



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FRACTIONAL PAYMENT BENEFICIARY DESIGNATION

I elect, in the event of my death the following beneficiary to receive the fractional portion of my retirement allowance for the month in which I die, if any is due. Note: Only one beneficiary is allowed for the Fractional Payment.

BENEFICIARY

First Name	M.I.	Last Name

Date of Birth <small>MM / DD / YYYY</small>	Relationship to Me	% of Benefit

Mailing Address	Apt. No.

City	State	Zip Code

REQUIRED – Telephone Number	REQUIRED – Email

POST RETIREMENT DEATH BENEFIT (CHAPTER 617)

I elect, in the event of my death after the effective date of my retirement that the benefit shall be paid to the following beneficiary(ies).

BENEFICIARY 1

First Name	M.I.	Last Name

Date of Birth <small>MM / DD / YYYY</small>	Relationship to Me	REQUIRED - % of Benefit

Mailing Address	Apt. No.

City	State	Zip Code

REQUIRED – Telephone Number	REQUIRED – Email

If more than one beneficiary is selected, you must select one of the following Otherwise or And

E _____			Board of Education Retirement System 65 COURT STREET BROOKLYN, NEW YORK 11201-4965
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POST RETIREMENT DEATH BENEFIT (CHAPTER 617)

I elect, in the event of my death after the effective date of my retirement that the benefit shall be paid to the following beneficiary(ies).

BENEFICIARY 2

First Name	M.I.	Last Name

Date of Birth <small>MM / DD / YYYY</small>	Relationship to Me	REQUIRED - % of Benefit

Mailing Address	Apt. No.

City	State	Zip Code

REQUIRED – Telephone Number	REQUIRED – Email

If more than one beneficiary is selected, you must select one of the following Otherwise or And

POST RETIREMENT DEATH BENEFIT (CHAPTER 617)

I elect, in the event of my death after the effective date of my retirement that the benefit shall be paid to the following beneficiary(ies).

BENEFICIARY 3

First Name	M.I.	Last Name

Date of Birth <small>MM / DD / YYYY</small>	Relationship to Me	REQUIRED - % of Benefit

Mailing Address	Apt. No.

City	State	Zip Code

REQUIRED – Telephone Number	REQUIRED – Email

If more than one beneficiary is selected, you must select one of the following Otherwise or And

If you wish to list additional beneficiaries, please list these additional beneficiaries on a separate sheet accordingly.

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OPTION 3: 5-YEAR CERTAIN/OPTION 4: 10-YEAR CERTAIN

I elect, in the event of my death after the effective date of my retirement that the benefit shall be paid to the following beneficiary(ies), under OPTION 3; 5-Year Certain/OPTION 4: 10-Year Certain.

PRIMARY BENEFICIARY

First Name _____ M.I. _____ Last Name _____

Date of Birth _____ Relationship to Me _____ **REQUIRED** - % of Benefit _____
MM / DD / YYYY

Mailing Address _____ Apt. No. _____

City _____ State _____ Zip Code _____

REQUIRED – Telephone Number _____ **REQUIRED** – Email _____

For the above Options, you may select a contingent beneficiary. Contingent

OPTION 3: 5-YEAR CERTAIN/OPTION 4: 10-YEAR CERTAIN

I elect, in the event of my death after the effective date of my retirement that the benefit shall be paid to the following beneficiary(ies), under OPTION 3; 5-Year Certain/OPTION 4: 10-Year Certain.

CONTINGENT BENEFICIARY

First Name _____ M.I. _____ Last Name _____

Date of Birth _____ Relationship to Me _____ **REQUIRED** - % of Benefit _____
MM / DD / YYYY

Mailing Address _____ Apt. No. _____

City _____ State _____ Zip Code _____

REQUIRED – Telephone Number _____ **REQUIRED** – Email _____

If more than one beneficiary is selected, you must select one of the following Otherwise or And