Member Enrollment Form

Last Revision: March 2016

BOSTON RETIREMENT SYSTEM
Boston City Hall, Room 816
Boston, MA 02201

Tel: 617-635-4311
Fax: 617-635-4318
Website: cityofboston.gov/retirement

Full Name:		SSN:
Former/Maiden Name:		Date of Birth:
Street Address:		
City:	State:	Zip:
Email:		Phone:
Marital Status: ☐ Married ☐ Single ☐ Divorced		

Position: _____

Start Date: _____

Agency or Department: _____

Are you a veteran? ☐ Yes ☐ No

Dates of military service: _____

The retirement law establishes specific periods of active service which may qualify you for certain Veteran benefits. A copy of military discharge (form DD-214) is required.

Past membership history with any other contributory retirement system(s) in Massachusetts:

RETIREMENT SYSTEM	FROM	TO	WAS REFUND TAKEN?	DO YOU WISH TO BUYBACK?*
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

*A member who re-enters service and is eligible to purchase creditable service will be billed at the buyback rate if an installment agreement is established within one year of the date of re-entry. The interest rate for a purchase of creditable service after your first year of re-entry is the full actuarial rate which is substantially higher than the buyback interest rate.

Do you currently receive or have you ever received a retirement allowance from another Massachusetts public retirement system? ☐ Yes ☐ No

Member's Last Name	First	M.I.	SSN

I hereby authorize the Treasurer to withhold the proper percent of my regular compensation due on each pay period and to deposit such deductions to my credit in the annuity savings fund. I understand the full amount of such deductions, with regular interest as provided by law, will be returned to me upon my written request if I terminate my service, unless I plan to accept a position which would entitle me to become a member of any other contributory retirement system in the Commonwealth. In the event that I die before retiring, my beneficiary or beneficiaries may receive survivor benefits or a refund of my accumulated total deductions as allowed by law.

I sign this form under the pains and penalties of perjury. I affirm that the information presented in this form is correct, complete and accurately presented. I understand that giving false or incomplete information may subject me to the loss of my benefits as well as civil and criminal penalties.

Employee's Signature: _____ Date: _____

Please make sure to file the below referenced forms with the Retirement Board only:

1) Beneficiary Selection Form - Lump Sum
2) Option D Beneficiary Selection Form (Optional)

Beneficiary Selection Form (Lump Sum)

Last Revision: May 2016

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I, (Print Name): _____, a member of the Boston Retirement System (BRS), hereby request the BRS to pay any sum referred to in G.L c. 32, § 11(2) due at my death to the following beneficiary or beneficiaries in the proportions designated.

My selection may be superseded by a selection under G.L. c. 32, § 12(2)(d) or if I die leaving an eligible spouse who elects to receive a monthly benefit.

I may change my beneficiary designation at any time.

I understand that my accumulated deductions in my account will be paid to my beneficiary(ies) if my death occurs prior to my retirement.

Any person or entity may be a beneficiary under G.L c. 32, § 11(2). Give complete name and address of each beneficiary below:

Designated Beneficiary(ies) - PRIMARY

Percentage
(total must equal 100%)

Name: _____ SSN: _____
Address: _____
Relationship: _____ DOB: _____
Phone: _____ Email: _____ _____%

Name: _____ SSN: _____
Address: _____
Relationship: _____ DOB: _____
Phone: _____ Email: _____ _____%

Name: _____ SSN: _____
Address: _____
Relationship: _____ DOB: _____
Phone: _____ Email: _____ _____%

Name: _____ SSN: _____
Address: _____
Relationship: _____ DOB: _____
Phone: _____ Email: _____ _____%

Beneficiary Selection Form (Lump Sum)

Last Revision: May 2016

Member's Last Name	First	M.I.	Member ID#

Designated Beneficiary(ies) – CONTINGENT – (OPTIONAL)

Percentage
(total must equal 100%)

Name: _____ SSN: _____
Address: _____
Relationship:_____DOB:_____
Phone:_____ Email:_____ _____%

Name: _____ SSN: _____
Address: _____
Relationship:_____DOB:_____
Phone:_____ Email:_____ _____%

Name: _____ SSN: _____
Address: _____
Relationship:_____DOB:_____
Phone:_____ Email:_____ _____%

Name: _____ SSN: _____
Address: _____
Relationship:_____DOB:_____
Phone:_____ Email:_____ _____%

Member Signature: _____ Date: _____
Member Address: _____

To be completed by witness (or BRS Staff) to member signature above. A designated beneficiary ***cannot*** witness form.

Signature of Witness: _____ Date: _____
Name of Witness (Print): _____

Option D Beneficiary Selection Form
(If Member Dies Before Retirement)

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The *Option D Beneficiary Selection Form* allows a member to select one eligible beneficiary to receive a retirement allowance for life, should the member die before retirement.

Keep in mind:

- An eligible beneficiary- for benefits under G.L c. 32, § 12(2)(d) ("Option D") is a spouse, former spouse who has not remarried, child, father, mother, sister or brother of the member.
- Your selection on this form may be superseded by an eligible spouse under the provisions of G.L. c. 32, § 12(2)(d) if you die before retirement.
- Should you nominate a person for an Option D benefit, they are ineligible for a lump sum benefit under § 11(2).
- You may update or change this beneficiary selection at any time.
- If you have any questions regarding this option, please contact a member services representative.

Option D Beneficiary Selection Form

Last Revision: May 2016

Member's Last Name	First	M.I.	Member ID#
_____	_____	_____	_____

I, (Print Name): _____, hereby nominate the beneficiary* listed below to receive from the Boston Retirement System, pursuant to G.L c. 32, § 12(2)(d), a benefit equal to the Option C retirement allowance, which would otherwise have been payable to me, in the event that I die before being retired. I understand that I may change my beneficiary designation at any time prior to my retirement and that upon my retirement this form becomes void.

I further understand that this choice of Option D Beneficiary may be superseded if I leave a spouse to whom I have been married for at least one year and with whom I am living with on the date of my death, or if living apart for justifiable cause, and I have at least two years of creditable service.

Choose ONE Eligible Beneficiary:

☐ Spouse ☐ Former Spouse (not remarried) ☐ Child ☐ Sibling ☐ Parent

_____

Name of Eligible Beneficiary

_____ _____

Beneficiary Date of Birth (*Attach birth record*) Beneficiary SSN

_____

Beneficiary Address

_____ _____

Beneficiary Email Beneficiary Phone

Member Signature: _____ Date: _____

Member Email: _____ Member Phone: _____

To be completed by witness to member signature above. The designated beneficiary ***may not*** witness.

Witness' Signature: _____ Date: _____

Witness' Name (Print): _____

**An eligible beneficiary is defined as the spouse, former spouse who has not remarried, child, parent or sibling of the member.*

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name: _____

Employee ID#: _____

Employer Name: _____

Employer ID#: _____

Your earnings from this job are not covered under Social Security (i.e., you will not pay Social Security taxes). This means that you will not earn credits for Social Security retirement or disability benefits in this job. If you retire or become disabled, and you are eligible for a Social Security benefit based on other work, your earnings from this job will not be used to compute your Social Security benefit. In addition, we will not consider these non-covered earnings for the future potential calculation of survivor benefits based on your earnings. Your earnings from this job are subject to Medicare taxes and will count for purposes of the Medicare program. For information on how you may qualify for Social Security benefits, visit www.ssa.gov.

For More Information

Social Security publications and additional information are available at www.ssa.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778 or contact your local Social Security office.

I certify that I have received Form SSA-1945 and understand that my earnings from this job are not covered under Social Security and will not be used to determine eligibility to or the amount of my potential future Social Security Benefits.

Signature of Employee: _____

Date: _____

Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

The Social Security Protection Act of 2004, Pub. L. No. 108-203, Section 419 requires State and local government employers to provide a statement to employees hired January 1, 2005, or later in a job not covered under Social Security. Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security**, is the document that employers must use to meet the requirements of the law.

While the earlier version of the SSA-1945 discussed the effect of the Windfall Elimination Provision and/or Government Pension Offset on an employee's potential future benefits, the Social Security Fairness Act (SSFA) of 2023 enacted on January 5, 2025, eliminated the reduction of Social Security benefits under the Windfall Elimination Provision and/or Government Pension Offset for individuals entitled to certain pensions from work not covered by Social Security, starting January 2024. However, this did not remove the requirement for State and local government employers to provide a statement to employees hired January 1, 2005, or later in jobs not covered under Social Security. This version of SSA-1945 explains to an employee that non-covered earnings will not be used to determine eligibility to or calculate the amount of potential future benefits.

Employers must:

- Get the employee's signature on the form
- Give the signed statement and information page to the employee prior to the start of employment
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

A fillable, downloadable version of the SSA-1945 is available online at the Social Security website, www.ssa.gov/online/ssa-1945.pdf.