

Part 1

Regional Conference Retirement Application

✓ Checklist

Retiree's Name _____

Conference _____

Part 1 forms to send:

<input type="checkbox"/>	Benefit Calculation Request Form - <i>(Be sure the retiree checks ALL options in which they would like to receive a benefit calculation)</i>
<input type="checkbox"/>	Proof of Age Form - <i>(for the Retiree)</i>
<input type="checkbox"/>	Copy of Birth Certificate/Passport - <i>(for the Retiree)</i>
<input type="checkbox"/>	Retirement/Termination Salary Form
<input type="checkbox"/>	Service Record – <i>(Years Totaled, Signed & Dated by Conf. Secretary)</i>
<input type="checkbox"/>	Pre-65 Healthcare Acknowledgement/Waiver Form <i>(if applicable)</i>
<input type="checkbox"/>	_____ Date your Conf. Exec. Cmte. approved the retirement

P.S. Conference Secretaries – Please be sure to double check the forms listed above for accuracy, signatures, etc. before mailing.

Send this cover checklist & original documents requested via a traceable carrier to:

Regional Conference Retirement Plan
7000 Adventist Blvd - Huntsville, Alabama 35896

FOR RETIREMENT OFFICE USE ONLY – DO NOT WRITE IN THIS AREA		
Part 1 sent to MOA via FedEx	Date:	Initials:

**Regional Conference Retirement
Seventh-day Adventist**

**RETIREMENT
BENEFIT CALCULATION REQUEST**

Send this form to the "Office of the Secretariat" of your Conference.

PARTICIPANT'S NAME		<input type="checkbox"/> MARRIED <input type="checkbox"/> UNMARRIED (Single, widowed, or divorced)	SOCIAL SECURITY NUMBER	DAY PHONE NUMBER ()
MAILING ADDRESS Street and Number	City	State	Zip Code	COMMITTEE APPROVAL DATE / /

I request a calculation of the following: (Check each option for which you desire a calculation.)

- a. **Non-Refund Life Annuity**
You will receive monthly payments for life. However, all payments cease when you die. (Note - Your spouse IS NOT ELIGIBLE for health care benefits from RCRP with this option)
- b. **Full Cash Refund Life Annuity**
You will receive monthly payments for life. If you die before your benefit payments equal the total present value of your benefit at retirement, your beneficiary will receive the balance of that amount in a single sum. Otherwise, payments cease upon your death. (Note - Your spouse IS NOT ELIGIBLE for health care benefits from RCRP with this option)
- c. **Period Certain and Continuous Annuity**
You will receive monthly payments for life. If you die before you have received 36, 60, 100, 120 or 180 monthly payments, your monthly benefit will continue to be paid to your beneficiary until a total of 36, 60, 100, 120 or 180 monthly benefits have been paid.
I elect to receive a life annuity with payments guaranteed for a minimum of (please select one):
 36 months 60 months 100 months 120 months 180 months
- d. **Joint and Survivor Life Annuity**
You will receive monthly payments for life. After your death, your joint annuitant, if living, will receive a lifetime monthly income equal to 50%, 66-2/3%, 75% or 100% of your monthly payment, depending on your selection at retirement. Payments will end upon the death of the last survivor.
After my death, my joint annuitant will receive a lifetime monthly income equal to (please select one):
 50% 66-2/3% 75% 100% of my monthly payment amount
- e. **Joint and Survivor with Period Certain and Continuous Annuity**
You will receive monthly payments for life. After your death, your joint annuitant, if living, will receive a lifetime monthly income equal to 50%, 66-2/3%, 75% or 100% of your monthly benefit, depending on your choice at retirement. You may choose to receive 36, 60, 120 or 180 guaranteed monthly payments. If you and your joint annuitant die before the guaranteed period ends, your beneficiary will receive the remainder of the annuity payments.
After my death, my joint annuitant will receive a lifetime monthly income equal to (please select one):
 50% 66-2/3% 75% 100% of my monthly payment amount
with payments guaranteed for a minimum of (please select one):
 36 months 60 months 120 months 180 months

Please provide the following necessary information about the joint annuitant:

Joint annuitant's name: _____ Male Female

Joint annuitant's date of birth: _____
(Month) (Day) (Year)

My joint annuitant is my: Spouse Child Other _____
(Relationship)

PARTICIPANT'S SIGNATURE	DATE
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REGIONAL CONFERENCE RETIREMENT**PROOF OF AGE REPORT***Send this form to the "Office of the Secretariat" of your Conference.*

EMPLOYER'S NAME	ADDRESS	CITY	STATE	ZIP CODE	EMPLOYER NUMBER
PERSON'S NAME FOR WHOM PROOF IS BEING PROVIDED			SOCIAL SECURITY NUMBER	DAY PHONE NUMBER ()	

The person above is a Participant Joint Annuitant Beneficiary Alternate Payee under a QDRO

If proof is for a Joint Annuitant, Beneficiary, or Alternate Payee, the Participant is:

Name: _____ Social Security Number: _____

TO THE PERSON SUBMITTING PROOF: Provide your proof with this completed form. You may then give this material to your Conference Secretary, who will complete the Employer's Section below, return the proof to you and send this form to the Office of the Plan Administrator in Huntsville, Alabama.

TO THE CONFERENCE SECRETARY: If you are satisfied with the proof submitted, please complete this form, return the proof to the person submitting it, and send the form, along with a copy of the proof, to the Plan Administrator.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

PROOF OF AGE**PREFERRED PROOF (Check and submit one of the following:)**

Birth Certificate Certification of Birth U.S. Passport U.S. Certificate of Citizenship

ALTERNATE PROOF (If Preferred Proof is unavailable, check and submit two (2) of the following that show birth date)

U.S. Driver's License Passport issued by foreign country Immigration record Infant Baptism Certificate
 Social Security Document Military Discharge record Primary school record Earliest hospital record

EXPLANATION (If one Preferred or two Alternate proofs above cannot be provided)

Explain here and submit this form with any proof available to your Conference Secretary for consideration.

PARTICIPANT'S DECLARATION

Under penalties of perjury, I hereby declare that the information provided above is true and accurate, to the best of my knowledge.

PARTICIPANT'S SIGNATURE	DATE
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CONFERENCE SECRETARY'S VERIFICATION

I have examined the evidence checked above, and I am satisfied that the correct date of birth is _____
MONTH DAY YEAR

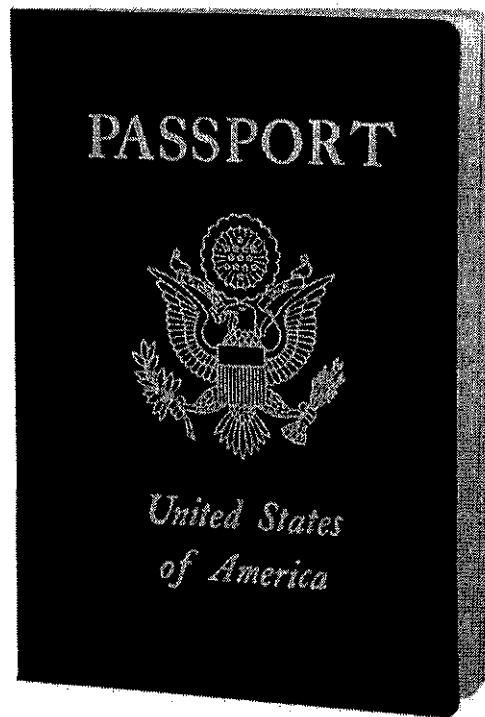
CONFERENCE SECRETARY'S SIGNATURE	DATE
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LEAVE BLANK

Approved by _____

Date _____

Copy of Retiree's



Birth Certificate,
Passport, Etc..

Goes here!

Regional Conference Retirement Supplemental Healthcare Benefits Plan

Healthcare Waiver/Acknowledgement Form

This Acknowledgement Form is to be used by an individual who is retiring prior to reaching the age sixty-five (65) and understands that he/she **WILL NOT** be entitled to Supplemental Healthcare Benefits in connection with the Regional Conference Retirement Plan until he/she reaches his/her sixty-fifth birthday.

You must have a minimum of 15 years of service in order to be eligible for the Supplemental Healthcare Benefits.

I. PARTICIPANT INFORMATION

Last Name	First Name	MI	SSN
Address	City	State	Zip Phone

II. ACKNOWLEDGEMENT OF NO PARTICIPATION IN SUPPLEMENTAL HEALTHCARE BENEFITS PLAN

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING THIS FORM:

Since I am retiring before reaching the age of sixty-five, I acknowledge that I **will not** be eligible to receive a current Supplemental Healthcare Benefits Plan in connection with the Regional Conference Retirement Plan.

I also understand that I will be eligible and advised to apply for this Supplemental Healthcare Benefits once I reach the age of sixty-five (65) and enroll in Medicare Part A and B coverage. **You must have a minimum of 15 years of service in order to be eligible for the Supplemental Healthcare Benefits.**

I understand that the information provided above is required in order for me to retire. I hereby authorize and consent to the use, release, and exchange of the above information between, my local conference, the Regional Conference Retirement Board, and, to be used solely in connection with the Supplemental Healthcare Benefits Plan. I confirm that all the information provided by me herein is accurate.

Retiree's Signature

Date

Notary Signature

Date

Seal

YOU MUST SUMMIT THIS ACKNOWLEDGEMENT WITH YOUR APPLICATION FOR RETIREMENT SIGNED, DATED AND NOTARIZED!