Revised 11-1-2011

Part 1

Regional Conference Retirement Application

✓Checklist

Retiree's Name _____

Conference _____

Part 1 forms to send:

☐	**Benefit Calculation Request Form -** *(Be sure the retiree checks ALL options in which they would like to receive a benefit calculation)*
☐	**Proof of Age Form -** *(for the **Retiree**)*
☐	**Copy of Birth Certificate/Passport -** *(for the **Retiree**)*
☐	**Retirement/Termination Salary Form**
☐	**Service Record –** (Years Totaled, Signed & Dated by Conf. Secretary)
☐	**Pre-65 Healthcare Acknowledgement/Waiver Form** *(if applicable)*
☐	_____ **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	◯ MARRIED ◯ 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

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

CONFERENCE SECRETARY'S VERIFICATION

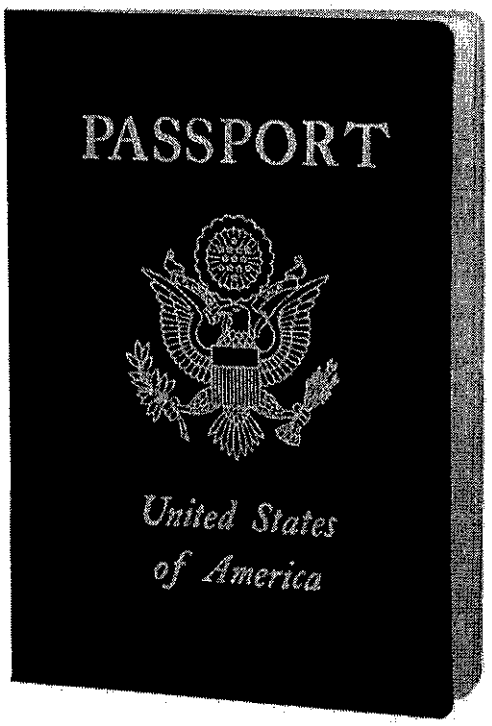
I have examined the evidence checked above, and I am satisfied that the correct date of birth is _____ (MONTH DAY YEAR)

CONFERENCE SECRETARY'S SIGNATURE	DATE

LEAVE BLANK

Approved by _____ Date _____

Copy of Retiree's



Birth Certificate, Passport, Etc..

Goes here!

REGIONAL CONFERENCE RETIREMENT PLAN

Defined Benefit Retirement Plan
REPORT OF TERMINATION, RETIREMENT, DEATH

EMPLOYER'S NAME	ADDRESS	CITY	STATE	ZIP CODE	EMPLOYER NUMBER

PARTICIPANT'S NAME	SOCIAL SECURITY NUMBER	DAY PHONE NUMBER
		( )

PARTICIPANT'S ADDRESS Number and Street	City	State	Zip Code

LAST DAY WORKED MONTH DAY YEAR	REASON FOR CESSATION OF PARTICIPATION		
/ /	◯ Termination of Service	◯ Disability	☐ Please check if 10-month contract.
	◯ Retirement	◯ Death	_____% of Base Rate

REPORT OF FINAL AVERAGE EARNINGS

DO NOT COMPLETE FOR NON-VESTED PARTICIPANTS.

(Amounts shown below are based on Consecutive Months of Service.)

(Teachers on a 10-month plan are calculated at actual percentage, up to 100% of the base rate.)

YEAR	PERIOD			SALARY
	Month/Year	Through	Month/Year	
1		*Through*		$
2		*Through*		$
3		*Through*		$
4		*Through*		$
5		*Through*		$

MARITAL STATUS OF DECEASED PARTICIPANT

◯ Single ◯ Married ◯ Widowed ◯ Divorced

SPOUSE'S FULL NAME			
SPOUSE'S ADDRESS *(if different from deceased participant's)* Number and Street			
City		State	Zip Code

EMPLOYER'S SIGNATURE

Before sending this form to Mutual of America, please be sure the participant or, if the participant is no longer living, the beneficiary, is given a copy of the Summary Plan Description.

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.

SIGNATURE OF EMPLOYER	DATE

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!

[redacted]

Revised 11/2011