Revised 11-1-2011

Part 2

Regional Conference Retirement Application

✓Checklist

(Part 2 is filled out <u>AFTER</u> Retirement Benefits letter is received from MOA)

Retiree's Name _____

Conference _____

☐	**Benefits Application Form** *(be sure retiree has chosen only **ONE** option)*
☐	**Joint Annuitant Form** *(Make sure that all info is listed)*
☐	**Waiver/Statement & Signature Form** *(Spouses signature/notarized – if applicable)*
☐	**Proof of Age Report—For SPOUSE** *(if applicable)*
☐	**Copy of Birth Certificate or Passport – For SPOUSE** *(if applicable)*
☐	**W-9 Tax Form** *(Make sure it is signed and dated)*
☐	**W-4P Tax Form** *(Make sure it is signed and dated & allowances claimed)*
☐	**NAD Acknowledgement and Release Form** *(a copy)*
☐	**MOA Direct Deposit Form & VOIDED Check** *(if applicable)*

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

<u>Send this cover checklist & original documents requested via a traceable carrier to:</u>

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

FOR RETIREMENT OFFICE USE ONLY – DO NOT WRITE IN THIS AREA		
Part 2 sent to MOA via FedEx	**Date:**	**Initials:**

Regional Conference Retirement
Seventh-day Adventist

BENEFITS APPLICATION

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

EMPLOYER'S NAME	CITY	STATE	ZIP CODE	PARTICIPANT IS: ◯ MALE ◯ FEMALE

PARTICIPANT'S NAME	DATE OF BIRTH / /	◯ MARRIED ◯ UNMARRIED (Single, widowed, or divorced)	SOCIAL SECURITY NO.

ADDRESS TO WHICH ANNUITY CHECKS SHOULD BE MAILED *(Please Print)* Street and Number	PARTICIPANT'S TELEPHONE NO. ( )	LEAVE BLANK CLAIM NUMBER
City State Zip Code	NORMAL RETIREMENT DATE	ACD /01/

LAST POSITION HELD	YEARS OF SERVICE
/ /	

WHEN YOUR BENEFITS BEGIN

Your Benefit Commencement Date must be the first day of a month that is no later than ___/___/___. We must receive your properly signed, completed Application before your requested Benefit Commencement Date.

I choose to have payments begin on | Benefit Commencement Date /01/ |

PROOF OF AGE

The amount of your pension is affected by your age when payments begin. Also, if you choose a Joint and Survivor Payment form, the amount you will receive depends on the age of your joint annuitant. Proof of age is needed before payments can begin. Acceptable documents proving age are listed in the PROOF OF AGE REPORT form.

PROOF OF AGE FOR:

YOURSELF
- ◯ is required now.
- ◯ has already been received.

Your JOINT ANNUITANT (if you elect a Joint and Survivor Payment form)
- ◯ is required now.
- ◯ has already been received.

YOUR CHOICE OF PAYMENT FORM

NOTE TO MARRIED RETIREES: If you do not choose the Joint and Survivor Payment form, or if you choose that form but name someone other than your spouse as Joint Annuitant, your spouse must sign the waiver. This must be done within 180 days before the date you have chosen to have your payments begin.

Please complete forms W-4P and W-9 (enclosed).

I elect the following payment option *(initial on line and check box corresponding with your election)*:

_____ 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

The beneficiary designation(s) on the reverse side of this form will only become effective for any benefit payments that may be payable after your Benefit Commencement Date (BCD). If you wish to change a pre-BCD designation, please contact your local service representative.

JOINT ANNUITANT (Complete this section only if you have elected a Joint and Survivor Payment form.)

After my death, benefits are to be paid to my Joint Annuitant named below.

NAME First Last	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP
ADDRESS Street and Number City		State	Zip Code

BENEFICIARY SECTION

After your death; and, if you have elected a Joint and Survivor Payment form with a period certain, after the death of your Joint Annuitant; any remaining benefits are to be paid to the beneficiary(ies) you list below.

If you name more than one primary or more than one secondary beneficiary, the death benefit will be paid in equal shares unless you show a different percentage (your figures for each beneficiary type must total 100%).

If no primary beneficiary is living when the death benefit is to be paid, the secondary beneficiary(ies) will receive the benefit. If no primary or secondary beneficiary is living at your death, the amount payable will be paid to the person(s) in the first surviving class of the following classes, in the following order: to (a) your surviving spouse, (b) your surviving children in equal shares, (c) your surviving parents in equal shares, (d) your surviving brothers/sisters in equal shares, or (e) the executors or administrators of your estate.

Name your beneficiaries in the space provided below. If you need more space, attach a page showing the necessary information for each beneficiary. Also include your name, Social Security number, signature and the date.

Beneficiary Type: ☒ Primary
Relationship: ◯ Spouse ◯ Child ◯ Parent ◯ Estate ◯ Other

FULL NAME First Initial Last	
DATE OF BIRTH (Optional) / /	SOCIAL SECURITY # (Optional)
ADDRESS Street	
City State Zip Code	
IF FOREIGN RESIDENT Province Country	BENEFIT PERCENT 0% %

Beneficiary Type: ☐ Primary ☐ Secondary
Relationship: ◯ Spouse ◯ Child ◯ Parent ◯ Estate ◯ Other

FULL NAME First Initial Last	
DATE OF BIRTH (Optional) / /	SOCIAL SECURITY # (Optional)
ADDRESS Street	
City State Zip Code	
IF FOREIGN RESIDENT Province Country	BENEFIT PERCENT 0% %

Beneficiary Type: ☐ Primary ☐ Secondary
Relationship: ◯ Spouse ◯ Child ◯ Parent ◯ Estate ◯ Other

FULL NAME First Initial Last	
DATE OF BIRTH (Optional) / /	SOCIAL SECURITY # (Optional)
ADDRESS Street	
City State Zip Code	
IF FOREIGN RESIDENT Province Country	BENEFIT PERCENT 0% %

Beneficiary Type: ☐ Primary ☐ Secondary
Relationship: ◯ Spouse ◯ Child ◯ Parent ◯ Estate ◯ Other

FULL NAME First Initial Last	
DATE OF BIRTH (Optional) / /	SOCIAL SECURITY # (Optional)
ADDRESS Street	
City State Zip Code	
IF FOREIGN RESIDENT Province Country	BENEFIT PERCENT 0% %

SPOUSE'S WAIVER (Witnessed by Notary Public)

I have received an explanation of the qualified joint and survivor annuity form of benefit payment offered by the above plan, and of the financial effect of electing the other forms of payment under the plan and the relative values of the various choices. I have also received all information which I have requested as permitted and described by that explanation. I have read and understood it and believe I have sufficient information to consent to my spouse's election. I also acknowledge that I received the explanation and other information requested by my spouse no more than 180 days before the Benefit Commencement Date requested in this Application. I am aware that I have the right to consider that explanation and information for at least 30 days before consenting to my spouse's election but by signing and submitting this Application earlier I specifically waive that minimum 30-day period.

SPOUSE'S SIGNATURE _____ DATE _____

SIGNATURE AND SEAL OF NOTARY PUBLIC OR SIGNATURE OF AUTHORIZED REPRESENTATIVE _____ DATE _____

Note: Notary's acknowledgement should be added below.

PARTICIPANT'S STATEMENT AND SIGNATURE

I have received an explanation of the qualified joint and survivor annuity form of benefit payment offered by the above plan, and of the financial effect of electing the other forms of payment under the plan and the relative values of the various choices. I have also received all information which I have requested as permitted and described by that explanation. I have read and understood it and believe I have sufficient information to make my election. I also acknowledge that I received the explanation and other information I requested no more than 180 days before the Benefit Commencement Date requested in this Application. I am aware that I have the right to consider that explanation and information for at least 30 days before making my election but by signing and submitting this Application earlier I specifically waive that minimum 30-day period.

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

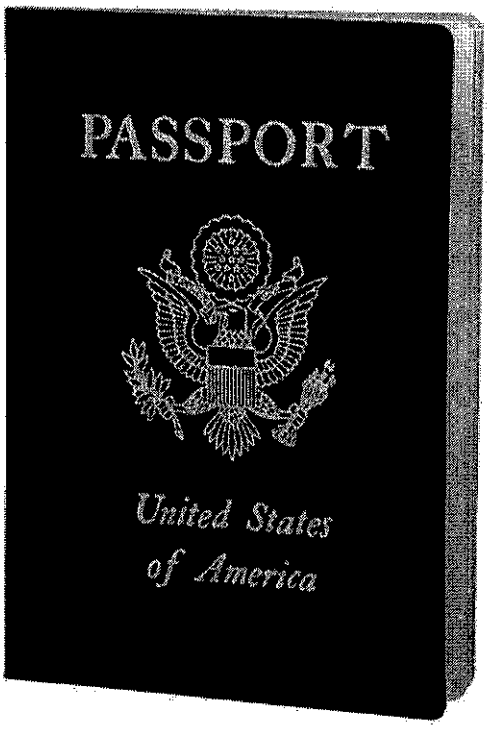
I have examined the evidence checked above, and I am satisfied that the correct date of birth is _____ (MONTH DAY YEAR)

CONFERENCE SECRETARY'S SIGNATURE	DATE

LEAVE BLANK

Approved by _____ Date _____

Copy of **SPOUSE**



Birth Certificate, Passport, Etc..

Goes here!

REGIONAL CONFERENCE EMPLOYEE ACKNOWLEDGEMENT AND RELEASE

I, the undersigned employee of the _____ Conference, have been provided with information by my employer explaining the retirement plan and retiree health care benefit program sponsored by my employer and several other Regional Conferences.

After reviewing the information provided to me on the new Regional Conference Retirement Plan and retiree health care benefit program, I understand and acknowledge that:

1. I will be credited with my service to the Church prior to January 1, 2000 for purposes of determining my retirement benefit under the Regional Conference Retirement Plan and retiree health care benefit program.

2. Neither the North American Division nor its existing retirement plans will be responsible for providing retirement benefits to me if the new Regional Conference Retirement Plan and retiree health care benefit program fails to provide the retirement benefits promised by my employer:

3. The responsibility for providing me with retirement benefits and retiree health care benefits now rests solely with my employer and the Regional Conference Retirement Plan and retiree health care benefits program;

4. The North American Division has not participated in the design or development of the Regional Conference Retirement Plan or retiree health care benefit program and is neither responsible for nor guarantees the accuracy of any information or representations that my employer has provided me about this plan or program;

5. The North American Division does not have any ongoing responsibility for funding the Regional Conference Retirement Plan and retiree health care benefit program: and

6. By signing and returning the Acknowledgement and Release, and in consideration for my opportunity to participate in the Regional Conference Retirement Plan and program, I agree to release the North American Division from responsibility and liability as set forth in paragraphs 2 through 5 above.

Signed this _____ day of _____, 2002.

_____ (Employee Signature)

_____ (Spouse Signature)

_____ (Print name)

_____ (Print Name)

[redacted]

Staple VOIDED check here

Mutual of America
Electronic Fund Transfers Election Form

Name:_____

Address:_____

_____

SS # or Federal ID#:_____

ABA#:_____

Account Number:_____

Account Type (check one):
◯ Checking ◯ Savings
Please attach a blank personal check marked VOID.

Name and Address of Bank:

Name:_____

Address:_____

_____

I authorize Mutual of America to make all benefit payments due to me by Electronic Fund Transfers to the bank account designated above.

Signature:_____

Date:_____

Telephone: ( )_____

For Mutual of America Use Only

MUTUAL OF AMERICA LIFE INSURANCE COMPANY
320 PARK AVENUE NEW YORK NY 10022-6839