



# ORP Enrollment/Change Form

**EMPLOYEE SECTION.** Please read and complete this section and return the form to your Human Resources office.

<b>First Name</b>	<b>MI</b>	<b>Last Name</b>	<b>Social Security #</b>	<b>Employee ID #</b>
<b>Home Address</b>	<b>City</b>	<b>State</b>	<b>ZIP Code</b>	<b>Date of Birth</b>
<b>Institution/Campus</b>	<b>E-mail Address</b>		<b>Daytime Telephone</b>	

### I. ELECTION

To enroll in the Massachusetts Optional Retirement Program (ORP), you must certify that the following statements are true: *(please initial on both lines)*

Initials required

I was provided with sufficient information regarding the State Employees' Retirement System (SERS) and the Optional Retirement Program with which to make an informed decision about my retirement plan, and **I further understand that my election is irrevocable**, and;

I am not vested in any retirement plan operating under Chapter 32 of the Massachusetts General Laws (typically the SERS, Massachusetts Teachers' Retirement, and county/municipal plans).

### II. OPTIONAL RETIREMENT PROGRAM PROVIDER

I elect to have my ORP contributions invested, and have established my ORP account online, with: *(check one)*

Fidelity     TIAA-CREF     VALIC

Printed proof of established account with provider must be included when returning this form.

### III. PRIOR PARTICIPATION

I have participated in the ORP previously through prior employment within the Commonwealth of Massachusetts:

Yes     No

### IV. SIGNATURE

Date: \_\_\_\_\_ Employee's Signature: \_\_\_\_\_

**ADMINISTRATOR SECTION.** To be completed by Human Resources office.

<b>Employee's Job Title</b>		<b>Date of Hire</b>	<b>Type of Enrollment (Check one)</b>	
			<input type="checkbox"/> New <input type="checkbox"/> Change in Provider <input type="checkbox"/> Rehire	
<b>Effective Date of ORP Eligibility</b>	<b>End Date of 180-day Election Period</b>	<b>Date of Payroll System Update</b>		<b>Plan Entry Date</b>

<b>Forms Required by DHE</b>	<b>Date Provided to Employee</b>	<b>Date Received from Employee</b>
Notice of Eligibility		
ORP Enrollment/Change Form		
Insurance Enrollment		
Proof of Enrollment with a Provider		
SSA-1945		
SERS Withdrawal <small>(not required at initial enrollment. Can be submitted at a later date)</small>		

Date: \_\_\_\_\_ Administrator Signature: \_\_\_\_\_