

Howard County Retirement Plan Benefit Election Form

3430 Court House Drive Ellicott City, MD 21043

Use this form to request payment of your retirement benefit from the Howard County Retirement Plan. You must also complete a tax withholding form, and a direct deposit form (if you wish to have your payments deposited directly into a bank account). All completed forms must be returned to the Office of Human Resources. If you have questions about this form, contact the Retirement Coordinator at (410) 313-3456 before signing it.

Partici	pant Information				
Name:		Social Security Number:	XXX-XX-	Date of Retirement:	
Address:					
		City		State	Zip +4 Code
Date of I	Birth:	Telephone No.:_			
Payma	nt Method (check one	Email Address:			
	<u>-</u>	e automatic payment metl	hod)		
□ N/A	NameSocial Security Num	vivor. Please provide the nber nmarried participants.		veficiary information	<i>:</i>
□ N/A	Option #2 – 100% Su Name Social Security Num	rvivor. Please provide th	ee following be	eneficiary informatio	n:
□ N/A	Option #3 – 50% Pop Name Social Security Num	Up. Please provide the f	Collowing bene	ficiary information:	
□ N/A	NameSocial Security Num	p Up. Please provide the nber nmarried participants.		eficiary information	•
	Please provide the followante	eed return of accrued be owing beneficiary informa- nber	ution:		
	Please provide the followard Name Social Security Number 1	eed return of employee cowing beneficiary informations of the company of the comp	ution:		
	Option #7 – Lump Su	m (a return of your contr	ibutions plus i	nterest)	

Direct Bank Deposit (check one)							
	I want my payments to be deposited directly into my bank account. (Attach a completed direct deposit authorization.)						
	I do not want my payments to be deposited directly into my bank account. Please mail the checks to me at the address shown on this form.						
		nce (if applicable)					
If you are eligible and want to enroll in the Howard County Retiree Health Insurance Program, check the box below and attach a completed health insurance deduction authorization form.							
	I want to enroll in the Howard County Retiree Health Insurance Program.						
	I am opting out of the Howard County Retiree Health Insurance Program at this time. I understand that I may enroll at a later date.						
I understand and accept the terms and conditions of the Howard County Retirement Plan as they affect the elections I have made on this form. I understand that I may not change the payment option, or my designated beneficiary, once I receive my first benefit payment. For retirees enrolling in retiree health insurance, I also understand and accept the terms and conditions of the Howard County Retiree Health Insurance Program. Signature:							
condition	ons of the Howa	etiree health insurance rd County Retiree Healt	I also h Insura	understand and accept the terms and ance Program.			
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Signatu Total mo Benefit S	ons of the Howard	etiree health insurance rd County Retiree Healt	I also h Insura	understand and accept the terms and ance Program. Date:			
Total mo Benefit S Date of F Health In	ons of the Howard	For Office of Hun	I also h Insura	understand and accept the terms and ance Program. Date: Ources Only W-4P Attached Maryland Withholding Exemption attached			