



**MCPS Core and Supplemental Retirement and Pension System**

**Retirement Forms Checklist**

**MCPS Core and Supplement Plan - Required Forms**

- \_\_\_\_\_ MCPS 455-2 Application for Retirement (*Include proof of your beneficiary's date of birth if selecting option C or D*)
- \_\_\_\_\_ MCPS 455-2B Addendum to Application for Retirement / Notice of Separation  
Resolution of Financial Obligation to MCPS
- \_\_\_\_\_ MCPS 455-5 Designation of Beneficiary
- \_\_\_\_\_ MCPS 281-50 Aetna Federal and Maryland State Tax Withholding Request
- \_\_\_\_\_ Aetna EFT Electronic Funds Transfer Authorization with "VOIDED" check
- \_\_\_\_\_ MCPS 455-22 Retiree Benefit Plan Enrollment  
(*Must include copy of Medicare Parts A and B card for any covered individual eligible for Medicare at retirement*)
- \_\_\_\_\_ MCPS 480-4 Notice of Termination/Retirement (Complete online)

**Optional Forms**

- \_\_\_\_\_ MCPS 455-26 Application for Lump Sum(De minimis) Retirement Distribution  
(*To determine if you are eligible for a deminimis lump sum distribution, run an estimate on Penpoint. Include this form if your monthly MCPS supplement retirement benefit is less than \$100.*)
- \_\_\_\_\_ MCPS 445-1 Change in Personal Information
- \_\_\_\_\_ MCPS 455-28 403(b) Leave Payout Contribution Agreement
- \_\_\_\_\_ MCPS 455-29 403(b) Leave Payout Contribution Agreement
- \_\_\_\_\_ Out-of-State Income Tax Withholding Form (Available online)

**Where/When To Send Forms**

ALL completed forms must be submitted **30 days** prior to the date of retirement to the following address:  
Montgomery County Public Schools  
Employee and Retiree Service Center (ERSC)  
45 West Gude Drive, Suite 1200  
Rockville, MD 20850

**Medicare Eligible Retirees/Spouses**

If you and/or your covered spouse are or will be 65 on the date of retirement, you must be enrolled in both Parts A and B of Medicare to remain with the MCPS medical and prescription benefits. **You must submit a copy of the Medicare card(s) with Parts A and B to ERSC 60 days prior to your retirement date in order to continue the medical and prescription benefits through MCPS.** You should contact the Social Security Administration at 1-800-772-1213 or [www.ssa.gov](http://www.ssa.gov) for information regarding Medicare benefits.



# Application for Retirement

Employee and Retiree Service Center  
MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS)  
45 West Gude Drive, Suite 1200, Rockville, Maryland 20850

MCPS Form 455-2  
October 2017

**INSTRUCTIONS:** Complete this form 30 days prior to the effective date of retirement and return to the Employee and Retiree Service Center. Employees must be eligible for retirement as of the effective date of retirement stated below.

**RETIREMENT TYPE**—Check ONE below.

- Normal Retirement     
  Ordinary Disability Retirement     
  Normal Vested Benefit  
 Early Retirement     
  Accidental Disability Retirement     
  Early Vested Benefit

**NAME (PLEASE PRINT)**

**EFFECTIVE DATE OF RETIREMENT** 7/01/2020

LEMON C EARLY  
First MI Last

EMPLOYEE ID NUMBER

SOCIAL SECURITY NUMBER

0000 XXXXX

Last 4 digits XXXX

Phone Number: 301-517-8100

E-mail Address: leary@marl.com

**PAYMENT OPTION SELECTION:** Check ONE below. Use MCPS Form 455-5 to designate beneficiaries. If selecting Option C or D, only ONE beneficiary can be designated. If the monthly benefit is less than \$100, distribution will be made in a one-time lump sum payment. State law mandates that an employee may receive either a worker's compensation payment or a disability retirement payment. If you are receiving a worker's compensation payment and have retired on disability, your monthly State/MCPS disability retirement benefit may be reduced. For more information see the ERSC Retirement Planning page and click on "Understanding Your Retirement" under General Retirement Resources.

**MAXIMUM:**

The maximum option provides the highest monthly benefit for your lifetime. All retirement benefits cease at your death.

**OPTION A:**

Option A provides a smaller monthly benefit than the maximum option. At the time of your death, any remaining balance of your contributions plus interest will be paid to your designated beneficiary(ies).

**OPTION B:**

Option B provides a smaller monthly benefit than Option A. At the time of your death, any remaining balance of the present value of your benefit will be paid to your designated beneficiary(ies).

**OPTION C:**

Option C provides a smaller monthly benefit than Option B. At the time of your death, 50% of the monthly benefit will be paid to your designated beneficiary for their lifetime. Proof of the designated beneficiary's date of birth must accompany this application. Your beneficiary cannot be changed after retirement.

**OPTION D:**

Option D provides a smaller monthly benefit than Option C. At the time of your death, 100% of the monthly benefit will be paid to your designated beneficiary for their lifetime. The designated beneficiary cannot be more than 10 years younger than you unless they are a spouse or disabled child. If the beneficiary is a disabled child, verification from a physician must be provided. Proof of the designated beneficiary's date of birth must accompany this application. Your beneficiary cannot be changed after retirement.

**MANDATORY LUMP SUM PAYMENT:**

If your benefit is less than \$100 per month, you will receive a mandatory payout of the present value of your retirement benefit in a lump sum with no benefit to your designated beneficiary. This lump sum payment also is known as a de minimis payment.

Check here to indicate that MCPS Form 455-5, Designation of Beneficiary/Beneficiaries is attached.

**Authorization and Acknowledgement**

I hereby authorize MCPS to distribute my retirement benefit as indicated above. I acknowledge that should my monthly benefit be less than \$100, my benefit will be disbursed in a mandatory one-time lump sum payment. I understand that the distribution of the lump sum payment makes any selected payment option above null and void.

I understand that my electronic submission of this form and my electronic signature are intended to be, constitute, and are equivalent to my personal signature.

Lemon Early  
Employee Signature

3/2/20  
Date

## Addendum to Application for Retirement/ Notice of Separation Resolution of Financial Obligation to MCPS

Employee and Retiree Service Center (ERSC) • Rockville, Maryland  
MONTGOMERY COUNTY PUBLIC SCHOOLS

### INSTRUCTIONS

Complete, sign electronically or manually, and return to the Employee and Retiree Service Center (ERSC). You may fax the signed form to 301-279-3651 or 301-279-3642, or email a PDF of the signed form to ERSC@mcpsmd.org.

### EMPLOYEE INFORMATION

Employee Name: Lemon Early Employee ID: XXXXXX  
Retirement Date: 7/1/2020 Resignation Date:     /    /    

If your financial obligation to MCPS is a result of salary overpayment, excess leave usage (negative earned leave), or an outstanding invoice for benefits, this liability will be reduced from your

- » upcoming paycheck(s)
- » pension refund or rollover check at separation of employment(resignation)
- » monthly pension payment from Maryland State Teacher's Pension system or MCPS core and/or supplement pension
- » Leave payout at separation of employment or retirement

#### Rescinding Your Retirement

You are only eligible for consideration to rescind your retirement if you have not received your first pension check. Your request to rescind your retirement and return to work in MCPS will be evaluated based on your current certification, skills, and/or experience, critical need of the employment area, as well as the availability of a vacant position. **Returning to MCPS as an employee, is not guaranteed and the position you currently occupy may no longer be available.**

You may contact ERSC at 301-517-8100 or via email should you need to rescind the application.

### AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby authorize MCPS to reduce my financial obligation from any payment disbursed to me as indicated above. I acknowledge that should my payment(s) indicated above be insufficient to satisfy my financial obligation to MCPS, then I will be billed for the excess amount and I am responsible to pay this amount by the due date provided on the invoice. I understand that my electronic submission of this form and my electronic signature are intended to be, constitute, and are equivalent to my personal signature.

Employee Signature: Lemon Early Date: 3/20/2020



# MCPS Core and/or Supplemental Pension Plans Designation of Beneficiary/Beneficiaries

MCPS Form 455-5  
October 2019

Employee and Retiree Service Center  
MONTGOMERY COUNTY PUBLIC SCHOOLS  
45 West Gude Drive, Suite 1200, Rockville, Maryland 20850

**INSTRUCTIONS:** Please return completed form to the address listed above. Print clearly. Retain a copy for your records.

Is this request to change your MCPS Core and/or Supplemental Pension Plan beneficiary/beneficiaries?  Yes  No

Working  Vested  Retired (if retiring, retirement date 7/01/20)

**IMPORTANT:** (If you are retired under Option C or D, STOP. You cannot change your beneficiary.)

EMPLOYEE ID NUMBER: 0000 XXXXX SOCIAL SECURITY NUMBER Last 4 digits XXXX

NAME (PLEASE PRINT)

First Lemon MI C Last EARLY

HOME ADDRESS

Street 6151 Richmond Street City Rockville State MD Zip Code 20850

Subject to the terms of the Montgomery County Public Schools Employees' Retirement Pension, and Reformed Pension System (Plan), I request that any sum becoming payable by reason of my death be payable to the following beneficiary/beneficiaries. (Enter name, address, social security number, and relationship to you.)

Check if you used an additional MCPS Form 455-5 to name additional primary beneficiaries.

**PRIMARY BENEFICIARY/BENEFICIARIES**

Relationship\* Spouse SS No. XXX-XX-XXXX Birthdate (MM/DD/YYYY) 2/11/57

Name Apply B. Early Address 6151 Richmond Street Rockville MD 20850

\*If spouse, please indicate state/jurisdiction where marriage license issued: Miami Date of marriage 5/3/69

Relationship \_\_\_\_\_ SS No. \_\_\_\_\_ Birthdate (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

**CONTINGENT BENEFICIARY/BENEFICIARIES** (if none of the above named Primary Beneficiary/Beneficiaries survive me.)

Check if you used an additional MCPS Form 455-5 to name additional contingent beneficiaries.

Relationship\* SON SS No. \_\_\_\_\_ Birthdate (MM/DD/YYYY) 5/11/70

Name Andrew B. Early Address 6151 Richmond Street Rockville MD 20850

Relationship\* \_\_\_\_\_ SS No. \_\_\_\_\_ Birthdate (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

I designate the above named person(s) as the beneficiary or beneficiaries to whom I request Montgomery County Public Schools (MCPS) to pay in the event of my death in active service, the total amount of the accumulated contributions standing to my credit in the Plan and, if I have completed at least one year of creditable service upon my death in active service, the death benefit as indicated in Section 13 of the Plan.

I hereby authorize Aetna Life Insurance Company to make payment to the beneficiary or beneficiaries, whom I have inserted above and agree on behalf of myself and my heirs and assigns, that payment so made shall be a complete discharge of the claim and shall constitute a release of MCPS from any further obligation on account of the benefit. I hereby direct that should both the primary and contingent beneficiary or beneficiaries of the above-named benefit predecease me, the amount which otherwise would have been payable to such beneficiary or beneficiaries, shall become a part of and be paid to my estate, or to such other beneficiary or beneficiaries as I shall hereafter nominate, by written designation filed with MCPS, in accordance with the rules and regulations prescribed by the Plan.

If more than one person is named beneficiary, any benefit payments that they may become entitled to receive from MCPS will, unless provided herein, be paid in equal shares to such of the designated persons, survivor or survivors, as shall be living at the time of my death.

Employee Signature Lemon Early

Date 3-2-20



# MCPS Employees' Retirement/Pension System Federal and Maryland State Withholding Request

MCPS Form 281-50  
August 2011

Employee and Retiree Service Center (ERSC)  
MONTGOMERY COUNTY PUBLIC SCHOOLS  
Rockville, Maryland 20850

**INSTRUCTIONS:** Before submitting this form to ERSC (new retirees) or Aetna (existing retirees), please consult examples #1-#4 on page 2. You must complete SECTION I. SECTION II is optional.

Social Security Number (last 4 digits) XXXX Print Full Name Lemon C Early

### SECTION I: FEDERAL TAX WITHHOLDING

Please check (✓) the appropriate block(s) indicating your election. You may select both SECTION I (Federal) and SECTION II (State).

Withhold Federal Income Tax block(s) indicating your election. You may select both #1 and #2, in which case the sum of the two choices will be withheld. **YOU MAY NOT SELECT ONLY #2.**

<input checked="" type="checkbox"/> <b>1. Marital Status</b> <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married	<b>Enter Number of Exemptions</b> 1 1 for yourself 1 1 for spouse _____ Additional	<input type="checkbox"/> <b>2.</b> Withhold from each monthly pension check the following whole dollar amount: \$ _____	<input type="checkbox"/> <b>3.</b> I do not wish to have Federal Income Tax withheld from my monthly retirement check. I realize that I am liable for payment of Federal Income Tax on the taxable portion of my benefit and that I am subject to tax penalties under the estimated tax payment rules if my payments of estimated tax and withholding are not adequate.
	<b>2 TOTAL EXEMPTIONS</b>		

### SECTION II: MARYLAND STATE INCOME TAX WITHHOLDING

Please check the appropriate box indicating your election. Check only one (1).

<input type="checkbox"/> <b>1.</b> I am NOT a Maryland resident. Do not withhold Maryland Income Tax. <input type="checkbox"/> <b>2.</b> I AM a Maryland resident, but I do not wish to have tax withheld.	<input checked="" type="checkbox"/> <b>3.</b> Withhold from each monthly pension check the following <b>WHOLE DOLLAR</b> amount (not less than \$5). \$ <u>50.00</u>
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**FOR STATES OTHER THAN MARYLAND, YOU WILL NEED TO CONTACT YOUR STATE OF RESIDENCE FOR THE APPLICABLE FORM.**

### SIGNATURE REQUIRED

Lemon C Early  
Signature

201 577 8100  
Telephone Number

3, 2, 20  
Date

### INCOME TAX WITHHOLDING FOR RETIREES

Each retiree is responsible to have the required Federal and State income taxes withheld based upon their overall income and projected tax liability. However, it is not necessary to have withholdings from each individual income source. Instead, retirees normally need to have one Federal and one State withholding account (depending upon your state of legal residence, and applicable state tax laws). Individuals who do not have enough income tax withheld may wish to file estimated taxes or they may be subject to penalties if their withholding is not adequate.

Some states exclude pension income from taxable wages while other states exclude pension income once you have attained a certain age, such as age 65. Other states treat pension income as fully taxable. Therefore, it is critical to familiarize yourself with the tax laws and withholding requirements of your state of residence or consult a qualified tax or financial advisor for additional questions or information.

Each year, you file Federal and State income tax returns to determine your actual tax liability. Then, based upon the amount withheld during the tax year, you will either owe additional taxes or receive a tax refund. As your income grows over time, you may need to increase your tax withholdings to insure that adequate taxes have been withheld. Several forms are used to establish or update the amount of federal and state taxes that are withheld from your pension. The forms you will need depend upon your state of residence, and whether you receive your core retirement benefit from the State Teachers' Retirement System or the MCPS Employee's Retirement/Pension System through MCPS' agent, Aetna, Inc.

The following four examples illustrate the common situations based upon plan membership and state of residence. Each example will explain the necessary forms and where to send them to establish or adjust your withholding amount.

[SEE PAGE TWO FOR EXAMPLES →]



# Electronic Funds Transfer (EFT) Authorization Form

Aetna Life Insurance Company  
 Large Case Pensions – RTAA  
 151 Farmington Avenue  
 Hartford, CT 06156-0665  
 Fax: 1-860-262-7412  
 Telephone: 1-800-952-2700  
 Email: [aetnapensions@aetna.com](mailto:aetnapensions@aetna.com)  
 Website: <https://pensions.aetna.com>

Payee/Joint Account Holder Information  To be completed by Payee. Please print.	Your Name (Last, First, Middle Initial) <i>Early Lemon C</i>	Social Security Number <i>XXX-XX-XXXX</i>	
	Address (Number & Street) <i>6151 Richmond Street</i>	Telephone Number <i>301-517-8100</i>	
	City/Town <i>Rockville</i>	State <i>MD</i>	ZIP Code – 4 Digit ZIP <i>20857</i>
	Joint Account Holder Name (Last, First, Middle Initial) <i>Early Apple B</i>	Joint Account Holder's Social Security Number <i>XXX-XX-XXXX</i>	

Financial Information  (U.S. ONLY)	I agree and acknowledge that you send my payments for automatic credit to:		
	Type of Account (please check one)	<input checked="" type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Other	
	Financial Institutional Name <i>MD Bank &amp; Trust</i>		
Bank Account Number <i>123456707</i>	ABA Routing Number (9 digits) <i>112233456</i>		

Payee/Joint Account Holder Agreement	<ul style="list-style-type: none"> <li>• Aetna will send payments to this account until I notify Aetna otherwise in writing.</li> <li>• If the payment due date falls on a weekend or holiday, we understand EFT payments will settle on the next day the Automated Clearinghouse (ACH) system is available.</li> <li>• I will advise Aetna of any change to information on this form, particularly any changes in resident address to facilitate the delivery of tax documents.</li> <li>• I will send Aetna proof of life upon request.</li> <li>• Joint Account Holder will notify Aetna immediately in the event of the Payee's death.</li> <li>• In the event of an overpayment, I/we agree that Aetna may debit the account receiving the payment automatically to recover the overpayment.</li> <li>• In the event that there are insufficient funds in this account to cover the overpayment, I/we direct the financial institution to release to Aetna any information on this account and Account Holders.</li> <li>• I confirm that my name is on the account provided.</li> </ul>
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Signatures	Payee's Signature <i>Early Lemon</i>	Date (mm/dd/yyyy) <i>3-2-20</i>
	Joint Account Holder's Signature (required if joint account) <i>Apple Early</i>	Date (mm/dd/yyyy) <i>3-2-20</i>

Pre-notification  Please be sure the information on this form is accurate and complete.	If EFT is available at your financial institution, processing this authorized form will cause your benefit payment to be transmitted via EFT provided all information is complete, accurate and received by Aetna in sufficient time to process your request.
	If you use an institution that is not a bank, it must be able to accept payments by EFT. If it cannot, EFT will not be available.

<p>Attach a voided personal check in the space provided.</p> <p>NOTE: When a voided check is provided, we will use the Bank Account Number, and ABA Routing Number displayed on the check, rather than anything written above.</p>	<p><b>Please attach VOIDED CHECK</b> (For checking account only)</p> <p><b>Note: If the type of bank account elected is Other, include a copy of your bank statement or a letter from the bank with the bank official's signature so that we may verify the name, address, account number and bank routing number.</b></p>
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# Retiree Benefit Plan Enrollment

Employee and Retiree Service Center (ERSC)  
MONTGOMERY COUNTY PUBLIC SCHOOLS  
45 West Gude Drive, Suite 1200 • Rockville, Maryland 20850

MCPS Form 455-22  
October 2019  
Page 1 of 2

**INSTRUCTIONS:** All new retirees must make a selection in each category. Complete, sign electronically or manually on both sides of this form, and return to the Employee and Retiree Service Center (ERSC). You may fax the signed form to 301-279-3651 or 301-279-3642, or e-mail a PDF of the signed form to ERSC@mcpsmd.org. This form must be signed at the bottom of pages 1 and 2. Please do not mail copies to ERSC once you have faxed or e-mailed the enrollment form. A confirmation of your requested change(s) will be sent to you. Unsigned forms will be returned to you and become your responsibility to resubmit to ERSC by the appropriate deadline.

**SECTION I: RETIREE INFORMATION**—Please print. If your address has changed, please submit MCPS Form 445-1, *Change in Personal Information* with your benefit enrollment form. Benefit enrollment confirmations are sent to the address on file.

Name Lemon C Early Employee ID # XX499X SSN # XXX X Last 4 digits 20850  
 Address 6151 Richmond STREET Rockville MD 20850  
Street City State Zip  
 Home Phone # 301-577-8100 E-mail leary@mail.com Retiree Date of Birth 8/14/56  
 Retirement Date 7/1/20 (new and existing retirees) Spouse Date of Birth 2/11/57

### SECTION II: RETIREE ENROLLMENT INFORMATION

- Continuation of Benefits in Retirement (new retirees only)
- Open Enrollment
- Transfer to active spouse MCPS plan (must include MCPS Form 455-20: *Employee Benefit Plan Enrollment*)
- Reenrollment/Qualifying Event (if coverage was canceled after 7-1-98)
- Change from POS to Medicare

- Drop dependent(s)
- Deceased dependent—date of death \_\_\_\_/\_\_\_\_/\_\_\_\_
- Change of Beneficiary only—skip to **SECTION VII, LIFE INSURANCE BENEFICIARY DESIGNATION**
- I **cancel/decline** all benefit plan enrollment effective \_\_\_\_/\_\_\_\_/\_\_\_\_ (Date of cancellation must adhere to *deadline rules in RBS*)—skip to **SECTION VI, LIFE INSURANCE OPTION**

### SECTION III: RETIREE LEVEL OF HEALTH COVERAGE

- Individual
- Two-Party
- Family

### SECTION IV: MANDATORY TOBACCO ATTESTATION

MCPS requires that you answer the following question **ONLY** if—  
• you and your spouse are covered by an MCPS-provided medical plan, AND  
• one or both of you are **NOT** eligible for Medicare.

Question: Answer **ONLY** for those who are **NOT** Medicare-eligible.  
Will you and your spouse be tobacco free throughout 2019?  Yes  No

**SECTION V: RETIREE BENEFIT PLAN ENROLLMENT INFORMATION**—You must make a selection in each category A-D. Please consult the Retiree Benefit Summary for benefit plan enrollment qualifications. **Medicare-eligible retirees (and their eligible dependents) must enroll in Medicare Parts A and B to continue coverage with MCPS.** If you enroll in a **private Medicare Part D plan**, all MCPS prescription coverage will be cancelled.

#### CATEGORY A (Medical Plans)—

**PLEASE SELECT ONE (1) OF THE FOLLOWING OPTIONS**

#### HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS

- CareFirst BlueChoice HMO/CareFirst Exclusive Provider Option (EPO) (an HMO option for retirees living outside the CareFirst service area)
- Kaiser Permanente HMO

#### OPEN POINT-OF-SERVICE (POS) PLANS<sup>1</sup>

- CareFirst BlueChoice Advantage

#### INDEMNITY/MEDICARE SUPPLEMENTAL PLANS

- CareFirst BlueChoice Advantage Indemnity/Medicare Supplemental Plan
- I **decline** medical coverage
- No change to **medical plan**<sup>2</sup>

#### CATEGORY B (Prescription Drug Plans)—Please select one

- Caremark (available to all non-Medicare-eligible retirees except Kaiser HMO members)
  - Option A
  - Option B
- SilverScript/Caremark Part D plan for Medicare-eligible participants (available to ages 65 + only)  Option A  Option B
- Kaiser (only available to Kaiser HMO members)
- I **decline** prescription drug coverage
- No change to **prescription drug plan**<sup>2</sup>

#### CATEGORY C (Dental Plans)—Please select one

- CareFirst Preferred Provider Organization (PPO)
- Aetna Dental Maintenance Organization (DMO) (Benefit plan participant must reside in a DMO service area.)
- I **decline** dental coverage
- No change to **dental plan**<sup>2</sup>

#### CATEGORY D (Vision Plan)—Please select one

- Davis Vision (provided through CareFirst)
- I **decline** vision coverage
- No change to **vision plan**<sup>2</sup>

<sup>1</sup>When a retiree or dependent becomes Medicare-eligible, your health plan will coordinate with Medicare. At that time, plan changes will be required.  
<sup>2</sup>If you are a new retiree, you may not select "No Change to Plan."

**SIGNATURE REQUIRED** I understand that my electronic submission of this form, and my electronic signature, are intended to be, constitute, and are equivalent to my personal signature.  
on pages 1 and 2

Lemon C Early  
Signature

3/2/20 (continue on reverse side)  
Date

**SECTION VI: COVERED PARTICIPANTS**—To enroll or drop dependent(s).

First Name	Last Name	MI	Social Security #	Date of Birth	Sex	Enroll/Drop
Spouse <u>Apple</u>	<u>Early</u>	<u>B</u>	<u>XXX-XX-XXXX</u>	<u>2-11-57</u>	<u>F</u>	<input checked="" type="checkbox"/> / <input type="checkbox"/>
Child						<input type="checkbox"/> / <input type="checkbox"/>
Child						<input type="checkbox"/> / <input type="checkbox"/>

**FOR ADDITIONAL COVERED DEPENDENTS, PLEASE ATTACH A SEPARATE SHEET OF PAPER.**

**SECTION VII: BASIC TERM LIFE INSURANCE**

Continue at retirement  
 I **cancel/decline** Basic Term Life Insurance (You may not reenroll once life insurance is cancelled.)  
 Change of beneficiary only  
 No change

**SECTION VIII: LIFE INSURANCE BENEFICIARY DESIGNATION**

- Benefits shall be divided equally among primary beneficiaries (or contingent beneficiaries), unless otherwise stated.
- The contingent beneficiary(ies) shall be entitled to life insurance benefits in the event there is no surviving primary beneficiary.
- If designating a Trust as a beneficiary, please provide a copy of the title, trustee, address, and signature pages of the Trust.

Please check **Primary** or **Contingent** for each designated beneficiary. If neither box is checked, the named beneficiary will be deemed as a **primary** beneficiary.

No change

**Primary**  
 Name Apple Early  
 Address 6151 Richmond ST Rockville MD 20850  
 Share 100 % Relationship Spouse

**Primary**  **Contingent**  
 Name Andrew B. Early  
 Address 6151 Richmond ST Rockville MD 20850  
 Share 100 % Relationship SON

**Primary**  **Contingent**  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Share \_\_\_\_\_ % Relationship \_\_\_\_\_

**Primary**  **Contingent**  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Share \_\_\_\_\_ % Relationship \_\_\_\_\_

**FOR ADDITIONAL BENEFICIARIES, PLEASE ATTACH A SEPARATE SHEET OF PAPER.**

This form must be signed for selections and designations to be valid. I understand that my electronic submission of this form, and my electronic signature, are intended to be, constitute, and are equivalent to my personal signature.

**SIGNATURE REQUIRED** Lemon Early 3/8/20  
on pages 1 and 2 Signature Date

Printed name Lemon Early Employee ID # XXXXXX



# NOTICE OF SEPARATION/TERMINATION OF EMPLOYMENT FROM MONTGOMERY COUNTY PUBLIC SCHOOLS

## **About this Form**

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**Form number:** 480-4

**Audience:** MCPS Staff

**Last revised:** April 2020

In response to the COVID-19 crisis, MCPS has revised the process for employees to terminate their employment with MCPS. Please follow the link below to the MCPS Careers web page and look under ANNOUNCEMENTS.

<https://www.montgomeryschoolsmd.org/departments/careers/>



# Application for Lump Sum (De minimis) Retirement Distribution

MCPS Form 455-26  
April 2014

Employee and Retiree Service Center  
MONTGOMERY COUNTY PUBLIC SCHOOLS  
45 West Gude Drive, Suite 1200, Rockville, Maryland 20850

**INSTRUCTIONS:** Complete this form 30 days prior to effective date of retirement, and return to the Employee and Retiree Service Center.

**RETIREMENT TYPE:**  Normal or Early Retirement  Disability Retirement—Ordinary  Disability Retirement—Accidental

**NAME (PLEASE PRINT)**

**EFFECTIVE DATE OF RETIREMENT** 7 / 01 / 2020

First Lemon MI C Last EARLY

**EMPLOYEE ID NUMBER:** 0000 XXXXY **SOCIAL SECURITY NUMBER Last 4 digits** XXXX

Home Phone 301 - 577 - 8100 E-mail Address leary.e@mail.com

**Payment Distribution Option:** I acknowledge that I have read the Rollover Options Notice, and I understand the tax consequences of my distribution and elect the following:

- 1. **Pay my entire distribution to me.** I understand that the taxable portion will be subject to the mandatory 20% federal income tax and if applicable, any state tax withholding.
- 2. **Rollover to a Traditional IRA**
- 3. **Rollover to a Roth IRA.** I understand that the taxable portion of this distribution will be taxable income, and I voluntarily request Aetna withholds \$ \_\_\_\_\_ in federal taxes and \$ \_\_\_\_\_.
- 4. **Rollover to a Qualified Retirement Plan**

**Please complete the financial institution rollover information:**

Direct my eligible rollover distribution to:  IRA  Roth IRA  Qualified Plan

Name of the Financial Institution Vandelay Industries

Account # 325678

Address 123 Main Street

New York NY 10022

Attention George COSTANZA

### REQUIRED CERTIFICATION

Under penalty of perjury, I hereby certify that all the information is correct. I acknowledge that I have read the Rollover Options Notice and have been advised of the tax consequences of my distribution and that under current law, I have 30 days in which to make this election. I hereby waive my right to the 30-day election period and request that my distribution be processed as soon as possible in the manner I have elected.

Employee Signature

Lemon Early

Date

3-7-20

# MONTGOMERY COUNTY PUBLIC SCHOOLS

## Change in Personal Information for MCPS Retirees and Former Employees

Employee and Retiree Service Center (ERSC)  
MONTGOMERY COUNTY PUBLIC SCHOOLS  
45 West Gude Drive, Suite 1200, Rockville, Maryland 20850

### INSTRUCTIONS (Please type or print)

Use this form to change or correct your name, title, date of birth, address, and/or Social Security number (only after receipt of your new official Social Security card). Complete this form, sign, and return it to the Employee and Retiree Service Center (ERSC). **You may fax the form to 301-279-3642/301-279-3651 or e-mail an electronically signed Adobe PDF file to ERSC@mcpsmd.org**

1. You must complete ALL sections in the first box.
2. You must go (in person) to your local Social Security Administration office to complete the required form to change your Social Security records. Requested name changes will only be processed as they appear on your Social Security card.
3. You will need to contact Aetna and the Maryland State Retirement Agency directly to update your address with these organizations.
4. If you are an MCPS retiree who is working in a substitute or temporary assignment, you must visit the Employee Self-Service (ESS) web page at [montgomeryschoolsmd.org/departments/ersc/employees/employee-self-service/](http://montgomeryschoolsmd.org/departments/ersc/employees/employee-self-service/) and click on **My address change** to update your address with MCPS for payroll purposes.
5. If you are an MCPS retiree who is working in a substitute or temporary assignment, you must complete a new W-4 if you change marital status and/or number of exemptions for income tax withholding purposes. All W-4 changes are made online. To access the online form, visit the ESS web page and click on **My W-4** under the green My Pay banner. Log in using your MCPS username and password and follow the on-screen instructions. After submitting your changes, you will receive an e-mail confirmation.

### EMPLOYEE INFORMATION

Name: Early, Lemon, C.  
Last, First, Middle

Effective date of change 7/1/20 Employee ID # XXXXX or Social Security # XXXXXXXXXX

### CHANGES

- CORRECT DATE OF BIRTH TO:** \_\_\_/\_\_\_/\_\_\_ Attach copy of birth certificate or valid driver's license.
- \_\_\_ **CHANGE TITLE TO:** 1 = Miss 2 = Ms. 3 = Mrs. 4 = Mr. 5 = Dr.
- CHANGE NAME TO** (Type or print former name above. **If name changed by court order, attach copy of order** e.g., marriage certificate, divorce decree):

\_\_\_\_\_  
Last, First, Middle

**CHANGE SOCIAL SECURITY NUMBER TO:** \_\_\_\_\_  
Attach copy of Social Security card

### CHANGE ADDRESS/PHONE

**From:**  
6151 Richmond Street  
Street  
Rockville  
City MD 20850 301.517.8100  
State ZIP Code Phone #

**To:**  
7151 Richmond Street  
Street  
Rockville  
City MD 20850  
State ZIP Code  
 Maryland County Montgomery

### SIGNATURE

I understand that my electronic submission of this form and my electronic signature are intended to be, constitute, and are equivalent to my personal signature.

Employee Name: (please print) Lemon Early

Employee Signature: Lemon Early Date 3/2/20

# MONTGOMERY COUNTY PUBLIC SCHOOLS

## MCPS Retirement \$403(b) Leave Payout Contribution Agreement

Chief Financial Officer, Division of Investments  
MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS)  
Rockville, Maryland 20850

### SECTION I—Employee Information (Please Print)

First Name Lemon Last Name EARLY

MCPS Employee ID (required) XXXXXX Retirement Date 7.1.20

Home Phone 301-517-8100 Work Phone \_\_\_\_\_

Union Affiliation:  MCAAP/MCBOA  MCEA  SEIU

### SECTION II—Earned Unused Leave Payout at Retirement Election

**Internal Revenue Service contribution limits for 2020:**  
Standard limit of \$19,500. Age 50 catch-up of an additional \$6,500.

I am eligible to contribute (based on IRS limits): \$ \_\_\_\_\_

Less YTD 403(b) contributions: \$ \_\_\_\_\_  I elect to contribute up to the maximum allowed.

Estimated amount eligible to contribute: \$ 0.00  I elect to contribute \$ \_\_\_\_\_

Value of my earned unused leave: \$ \_\_\_\_\_

**Important notice:** If you return to work for MCPS in ANY CAPACITY and are under age 59½ you become ineligible for a distribution based on separation of service regardless of whether or not you are receiving a pension benefit.

### SECTION III—Agreement and Signature

I elect to contribute a portion of my earned unused leave to my MCPS Fidelity 403(b) account and hereby direct MCPS to reduce my leave payout by the amount elected in Section II. MCPS will remit my leave payout contribution to my 403(b) account at Fidelity Investments. Please visit [www.NetBenefits.com/mcps](http://www.NetBenefits.com/mcps) to register and log in to your account.

I understand and agree that:

- Incomplete forms will be returned to me via Pony;
- This agreement must be submitted with my retirement forms 30 days prior to my retirement date;
- This agreement is binding and irrevocable with respect to amounts paid or made available while this agreement is in effect unless I submit a revised form to the retirement team at Employee and Retiree Services Center (ERSC) at least 2 weeks prior to my retirement;
- This agreement shall remain in effect for the duration of my employment with MCPS or until changed or terminated by me or MCPS in accordance with the procedures outlined in the Plan document;
- I am responsible for performing, or having performed on my behalf, the calculations to determine my maximum contribution amount, and;
- By signing this 403(b) Leave Payout Agreement, I certify that my salary reduction contributions, including the amount of my estimated leave payout, do not exceed 88% of the approved leave payout up to the maximum annual contribution limits of Sections 415(c)(1), 403(g), and 414(v) of the Internal Revenue Code.

Employee Signature Lemon Early Today's Date 3.17.20

For answers to Leave Payout questions, please see 403(b)/457(b) Leave Payout FAQs, also available under Tools & Resources at [www.NetBenefits.com/mcps](http://www.NetBenefits.com/mcps).

**Completed form should be delivered to:**  
**MCPS/ERSC**  
**Attn: Retirement Team**  
45 West Gude Drive, Suite 1200, Rockville, MD 20850

*As a plan participant, you are solely responsible for the review and selection of any and all plan investment options. You must review investment choices offered by the MCPS plans carefully before making any investment decisions. Neither MCPS nor any of its employees has any liability or responsibility for investment options that you select.*

**MCPS Use Only**

Initials: \_\_\_\_\_

Date Input: \_\_\_\_/\_\_\_\_/\_\_\_\_

**MONTGOMERY COUNTY PUBLIC SCHOOLS**

**MCPS Retirement  
§457(b) Leave Payout Contribution Agreement**

Chief Financial Officer, Division of Investments  
MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS)  
Rockville, Maryland 20850

**SECTION I—Employee Information (Please Print)**

First Name Leman Last Name Early  
 MCPS Employee ID (required) XXXXXX Retirement Date 7/1/20  
 Home Phone 301-517-8100 Work Phone \_\_\_\_\_  
 Union Affiliation:  MCAAP/MCBOA  MCEA  SEIU

**SECTION II—Earned Unused Leave Payout at Retirement Election**

**Internal Revenue Service contribution limits for 2020:  
Standard limit of \$19,500. Age 50 catch-up of an additional \$6,500.**

I am eligible to contribute (based on IRS limits): \$ \_\_\_\_\_  
 Less YTD 457(b) contributions: \$ \_\_\_\_\_  I elect to contribute up to the maximum allowed.  
 Estimated amount eligible to contribute: \$ 0.00  I elect to contribute \$ \_\_\_\_\_  
 Value of my earned unused leave: \$ \_\_\_\_\_

**Important notice:** The 457(b) plan permits distributions based on separation of service or age 70½. If you return to work for MCPS in ANY CAPACITY you become ineligible for a distribution based on separation of service regardless of whether or not you are receiving a pension benefit.

**SECTION III—Agreement and Signature**

I elect to contribute a portion of my earned unused leave to my MCPS Fidelity 457(b) account and hereby direct MCPS to reduce my leave payout by the amount elected in Section II. MCPS will remit my leave payout contribution to my 457(b) account at Fidelity Investments. Please visit [www.NetBenefits.com/mcps](http://www.NetBenefits.com/mcps) to register and log in to your account.

I understand and agree that:

- Incomplete forms will be returned to me via Pony;
- This agreement must be submitted with my retirement forms 30 days prior to my retirement date;
- This agreement is binding and irrevocable with respect to amounts paid or made available while this agreement is in effect unless I submit a revised form to the retirement team at Employee and Retiree Services Center (ERSC) at least 2 weeks prior to my retirement;
- This agreement shall remain in effect for the duration of my employment with MCPS or until changed or terminated by me or MCPS in accordance with the procedures outlined in the Plan document;
- I am responsible for performing, or having performed on my behalf, the calculations to determine my maximum contribution amount, and;
- By signing this 457(b) Leave Payout Agreement, I certify that my salary deferral contributions, including the amount of my estimated leave payout, do not exceed 88% of the approved leave payout up to the maximum annual contribution limits of Sections 457(b) and 414(v) of the Internal Revenue Code.

Employee Signature Leman Early Today's Date 3/2/20

For answers to Leave Payout questions, please see 403(b)/457(b) Leave Payout FAQs,  
also available under Tools & Resources at [www.NetBenefits.com/mcps](http://www.NetBenefits.com/mcps).

**Completed form should be delivered to:  
MCPS/ERSC  
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*As a plan participant, you are solely responsible for the review and selection of any and all plan investment options. You must review investment choices offered by the MCPS plans carefully before making any investment decisions. Neither MCPS nor any of its employees has any liability or responsibility for investment options that you select.*

MCPS Use Only	
Initials: _____	
Date Input: ____/____/____	