Revised 11-1-2011

Regional Conference Worker or Retiree

* Death Claim Form

(***NOTE** – you CANNOT send this directly to MOA – it must be sent to the RCRP office for processing)

Please Print

Deceased Name _____

Conference _____

Death Claim Checklist:

☐	**ORIGINAL** Death Certificate ***(MUST be the original – copies WILL NOT be accepted)***
☐	Termination, Retirement, Death Salary Form *(not applicable for a current retiree)*
☐	Service Record - Totaled, Signed & Dated *(not applicable for a current retiree)*
☐	**Spouse/Survivor Contact Information *(Please Print):*** Name _____ Relationship _____ Address _____ City _____ State _____ Zip _____ Home # ( ) _____ Cell # ( ) _____

Send this cover form and original documents requested to:

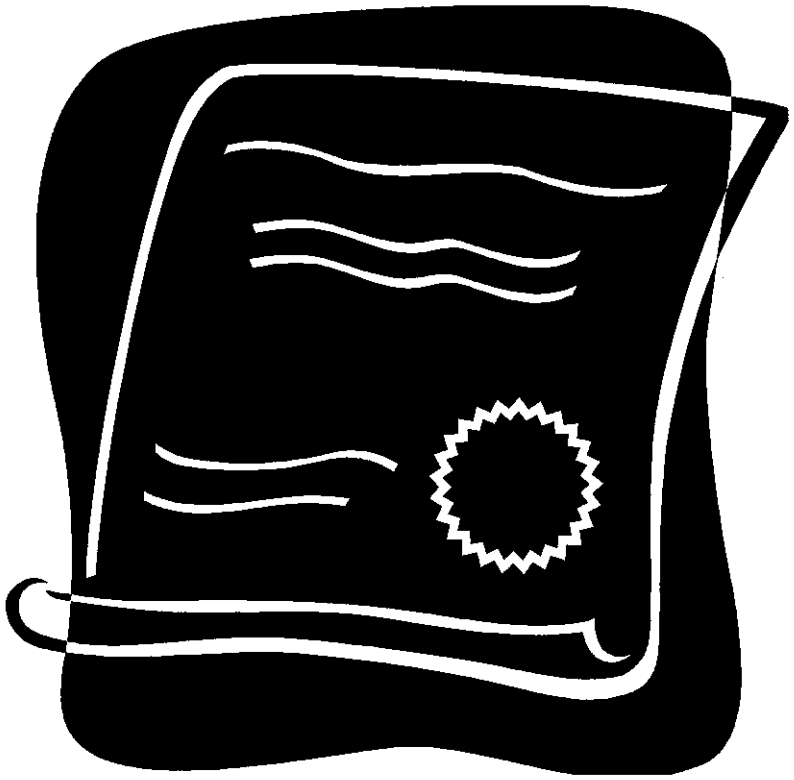
Regional Conference Retirement Plan
7000 Adventist Blvd - Huntsville, Alabama 35896

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

ORIGINAL

(NO copies will be accepted – it MUST be an ORIGINAL)

Death Certificate



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. _____% of Base Rate
	☐ Retirement	☐ Death	

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