Ref ID:

AGENT/GUARDIAN

EA

IMMEDIATE ACTION REQUIRED – RETURN BY August 01, 2019

To avoid having a delayed payment, please mail completed and notarized form to:
MEABF, 321 N. Clark Street Suite 700, Chicago, IL 60654. DO NOT FAX the form.
If you have any questions, please call 312-236-4700 press 2 or ask for Annuitant Services.

P/A NAME for ANNUITANT'S NAME
ADDRESS

_____

_____

_____

If you have a change of address
please write it on the lines above.

Municipal Employees' Annuity and Benefit Fund of Chicago
AFFIDAVIT - Continuing Benefit Eligibility

This affidavit is executed under penalty of perjury of the laws of the United States and State of Illinois.

My name is NAME , designated agent for ANNUITANT'S NAME (ANNUITANT). I declare that:

1. To the best of my knowledge, The ANNUITANT (Check applicable box)
   - ❑ Is still alive and is residing with me.
   - ❑ Is still alive but NOT residing with me. Annuitant phone #: (_____)_____

   Annuitant address: _____
   - ❑ Annuitant is residing in a healthcare facility. Attach statement from facility.

   Name and address of Healthcare Facility: _____

   _____Phone#: _____
   - ❑ Is deceased, died on _____. Attach copy of death certificate. (Contact MEABF at 312-236-4700 press 2).
2. I acknowledge and agree that as agent or guardian, it is my duty to immediately report any changes to the MEABF such as annuitant dies; annuitant moves; joint account holder name added or removed; or I am no longer the agent or guardian.
3. The annuitant's pension benefit is currently being deposited to a bank account in which I have access or a check is paid to me as agent for the benefit of the ANNUITANT. I agree that in the event the aforementioned ANNUITANT dies, I am legally responsible to return to MEABF all monies received after the ANNUITANT's death to which the ANNUITANT was not entitled. I also understand that it is a crime, punishable under Illinois law, to collect or cash a deceased person's pension benefit payment.

At least one of the following must be included with this Affidavit:

- Statement from the annuitant's primary physician stating that the annuitant has been seen and evaluated within the last sixty (60) days. Letter must be on the letterhead of the physician with the physician's address, phone number, license number and signature. Health information under HIPAA should not be included on the physician's letter, **OR**
- Currently dated letter from healthcare facility indicating annuitant is currently residing in the facility. Letter must be on their letterhead signed by an administrator or authorized officer. No statements or bills.

Signature and Notary

I certify, under penalty of perjury, that the information provided hereon is true and correct to the best of my knowledge. I understand that any person who willingly makes any false statement, or falsifies, or permits to be falsified, any record in an attempt to defraud MEABF is guilty of a Class 3 felony. A "statement" or "record" includes, but is not limited to, this Affidavit.

Signature of Agent or Guardian _____ Date: _____

Daytime Phone #: (_____)_____ Cell Phone #: (_____)_____

State of _____, County of _____

Signed or attested before me on _____/_____/_____

I certify under the penalty of perjury that this is true and correct.

Notary's Printed Name: _____ Commission expires: _____

(Notary Seal) Notary's Signature: _____

Revised 04/01/2019