



TO: New Hire

FROM: Human Resources

RE: **ABP RETIREMENT ENROLLMENT**

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### **WELCOME TO HUDSON COUNTY COMMUNITY COLLEGE**

The New Jersey Division of Pension and Benefits requires Local Education Employees to enroll in a pension plan, **Alternative Benefit Program (ABP)**. Your enrollment effective date is your exact start date.

If you choose not to complete the enrollment benefits forms, you will automatically be enrolled. *Below is a brief description of your pension plan.*

**ABP** – Is a defined contribution retirement program and members contribute 5% of their salary, with an 8% employer match. ABP provides life insurance that is 3.5 times base salary, at no cost to you. There are seven carriers to choose from. *Note, you must contact the carrier of your choice to establish an account with them. **By regulation, if a carrier is not chosen, one will be elected for you.***  
*(Carrier chosen will be the default carrier assigned to HCCC)*

Thank you,

Office of Human Resources



**DIVISION OF PENSIONS & BENEFITS — DEFINED BENEFIT & DEFINED CONTRIBUTION BUREAU**

P.O. Box 295, Trenton, NJ 08625-0295

**ALTERNATE BENEFIT PROGRAM (ABP) — ENROLLMENT APPLICATION**

See page 2 for instructions on completing this form.

**PART 1 - MEMBER INFORMATION**

1. Name: \_\_\_\_\_  
First Middle Last
2. Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: Male  Female   
Month Day Year
3. Address: \_\_\_\_\_  
Street City State Zip Code
4. Phone Number: ( \_\_\_\_ ) \_\_\_\_\_ — \_\_\_\_\_ 5. Social Security Number: \_\_\_\_\_
6. Have you ever been a member of a New Jersey State-administered retirement system?  Yes  No  
 If yes, check fund and indicate membership number:  ABP  PERS  TPAF  PFRS  SPRS  
 Membership number: \_\_\_\_\_ Are you retired from this retirement system?  Yes  No
7. Are you eligible for immediate vesting in the ABP? (See eligibility criteria on page 2.)  
 Yes  No If yes, identify how you qualify: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Applicant*

\_\_\_\_\_  
*Date*

**PART 2 - CASH DISTRIBUTION (VESTED MEMBERS ONLY)**

A member of the Alternate Benefit Program (ABP) becomes eligible to commence distributions at any age upon severance from employment or retirement. Members may receive benefits in the form of an annuity or cash distribution. Annuity benefits will be calculated by the Designated Service Provider (DSP) based upon the account accumulation, life expectancy, and the distribution option selected. Cash distributions to members under the age of 55 are limited to their employee contributions and accumulations. The remaining employer contributions and earnings are available for distribution upon attaining age 55. Participation in the ABP shall terminate and the individual shall be considered retired once he or she has elected to receive a distribution of the value of his or her accounts in a direct payout as a cash distribution, a rollover, or an annuity (or a combination of these distributions). The member is considered retired and is not eligible to enroll in any New Jersey State-administered retirement system, nor is he/she eligible to re-enroll in the ABP.

I hereby acknowledge that I have been counseled regarding my election to withdraw funds from my mandatory 401(a) account.

\_\_\_\_\_  
*Signature of Applicant*

\_\_\_\_\_  
*Date*

**PART 3 - CERTIFICATION OF EMPLOYING AGENCY (To be completed by the employer.)**

- Title of Position: \_\_\_\_\_ Employed:  10  12 months Appointment Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Employing Institution: \_\_\_\_\_ Location Number: \_\_\_\_\_ Annual Base Salary \$ \_\_\_\_\_
- Full-Time Employee:  Yes  No Academic Position:  Yes  No  
 Bachelor's Degree:  Yes  No Administrative Position:  Yes  No  
 Immediately Vested:  Yes  No Adjunct/Part-Time Faculty:  Yes  No

I certify that this employee and position meets the eligibility criteria for the retirement system as provided by law. I acknowledge that I am subject to penalty for falsifying or permitting to be falsified any record, application, form, or report of the retirement system in an attempt to defraud the system pursuant to N.J.S.A. 43:3C-15. Two signatures required.

Certifying Officer: \_\_\_\_\_  
Print Name Signature Date

Certifying Officer's Supervisor: \_\_\_\_\_  
Print Name Signature Date

## GENERAL INFORMATION

**Eligibility** — All full-time faculty and administrative personnel required to possess a Bachelor's Degree are eligible for enrollment in the ABP. Adjunct faculty and part-time instructors are also eligible for enrollment in the ABP under the provisions of P.L. 2008, c. 89 (Chapter 89). Other employees hired in a temporary position are not eligible. Employees earning less than 50 percent of the normal base salary are not eligible. Employees with F or J visas are not eligible.

**Note:** A retiree from any New Jersey State-administered retirement system is ineligible to participate in the ABP.

**Vesting Eligibility Criteria** — A member is immediately vested if he/she owns a retirement contract that contains both employer and employee contributions that is based upon employment in the field of higher education or transfers an active or vested New Jersey State-administered retirement system account to the ABP. The retirement contract must be in force, i.e., the employee is entitled to receive benefits at a future date. The member is also immediately vested if he/she is an active or vested member of a state-administered retirement system of any state in the United States.

**Individuals Age 60 Or Older** — To be covered by the group life and long-term disability insurance programs, you must submit to a medical examination to prove insurability. A medical examination will be arranged for you. Upon advice from the insurance carrier that you have proved insurability, you will be covered.

**Service Credit** — Pension membership credit begins to accrue from the date you become eligible for enrollment in the ABP.

**Investment Carrier Selection** — ABP members must complete an *Alternate Benefit Program (ABP) Carrier Election and Allocation* form and the application forms of each investment carrier selected.

## INSTRUCTIONS FOR COMPLETING THE APPLICATION

All applications should be submitted online using the Employers' Pensions and Benefits Information Connection (EPIC). In the event that you cannot complete the *ABP Enrollment Application* online, please mail this completed application to the address below.

Parts 1 & 2 are to be completed by the employee. Part 3 is to be completed by the employer.

**ITEMS 1 - 5** — Please complete all items.

**ITEM 6** — If you were recently a member of the Teachers' Pensions and Annuity Fund (TPAF), the Police and Firemen's Retirement System (PFRS) or the Public Employees' Retirement System (PERS) and did not withdraw your contributions from that retirement system, you may remain in, or transfer into, the PERS and waive participation in the ABP. You may obtain a proper transfer form from your human resources office. However, if you elect to participate in the ABP, this *Enrollment Application* must be completed and submitted with the appropriate application to transfer contributions to the ABP.

**ITEM 7** — See vesting eligibility criteria above. If you answer "Yes," employer and employee contributions vest immediately. If you answer "No," employer and employee contributions are remitted to the one investment carrier you select. However, the employer contributions are not vested until your 13th consecutive month of employment. If you terminate employment prior to your 13th month, the employer contributions are returned to your employer.

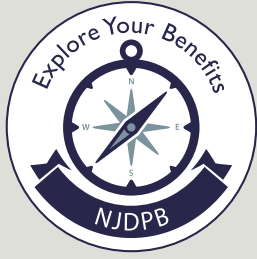
**APPLICANT SIGNATURES** — All applicants must sign and date Part 1. Vested members must also check the box, sign and date Part 2, acknowledging that they have read the cash distribution information.

**GROUP LIFE INSURANCE AND DESIGNATION OF BENEFICIARY** — The designation of beneficiary is not a part of this application. Upon enrollment, a new ABP member's estate is automatically designated as the beneficiary for any death benefit. New members should update their beneficiary information by completing an *ABP Designation of Beneficiary* form and submitting it to the New Jersey Division of Pensions & Benefits (NJDPB).

You may change your beneficiary designation for the group life insurance at any time. The change must be filed with the NJDPB and supersedes any previous designation on file. The *ABP Designation of Beneficiary* form is available from the employer or on the NJDPB website at: [www.nj.gov/treasury/pensions](http://www.nj.gov/treasury/pensions)

This does not change your beneficiary designation for your annuity. Contact your individual investment carrier(s) for changes to your annuity.

**Return this completed form to:** **New Jersey Division of Pensions & Benefits**  
**Defined Benefit & Defined Contribution Plans Reporting Bureau**  
**P.O. Box 295**  
**Trenton, NJ 08625-0295**



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**DIVISION OF PENSIONS & BENEFITS — DEFINED BENEFIT & DEFINED CONTRIBUTION BUREAU**

P.O. Box 295, Trenton, NJ 08625-0295

**ALTERNATE BENEFITS PROGRAM (ABP)  
CARRIER ELECTION AND ALLOCATION**

Name \_\_\_\_\_  
*Last*
*First*
*MI*

Social Security Number \_\_\_\_\_ ABP Number \_\_\_\_\_  
*if assigned*

Address \_\_\_\_\_  
*Street*

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\_\_\_\_\_ *City* *State* *Zip*

Daytime Telephone Number ( \_\_\_\_\_ ) \_\_\_\_\_

**AUTHORIZED INVESTMENT CARRIERS**

If you are vested, select any number of investment carriers and allocate the percentage of your contributions to each one, totaling 100 percent. Percentages must be whole numbers. You must establish a valid account directly with the carrier(s) you select.

Check One:     Initial Election         Subsequent Election

- |       |   |             |
|-------|---|-------------|
| _____ | AXA Financial (Equitable)                     | _____ %     |
| _____ | MassMutual Retirement Services (The Hartford) | _____ %     |
| _____ | ING/VOYA Financial Services                   | _____ %     |
| _____ | MetLife (formerly Travelers/CitiStreet)       | _____ %     |
| _____ | Prudential                                    | _____ %     |
| _____ | TIAA-CREF                                     | _____ %     |
| _____ | VALIC   | _____ %     |
|       |   | <b>100%</b> |

I elect to allocate my total employee and employer tax sheltered contributions as indicated above. This allocation becomes effective within 30 days of receipt of a properly completed form. I have read and understand the information on the back of this application about my ABP membership.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Certifying Officer Signature \_\_\_\_\_ Date \_\_\_\_\_

Certifying Officer's Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

## ABP

### **Information For New Applicants**

A *Carrier Election and Allocation* form must be completed to identify the investment carrier(s) with which you want your contributions invested.

If you are eligible for immediate vesting, the employer contributions become your property immediately upon investment in your account. You may elect any number of investment carriers and designate the percentage (in whole numbers) of the total contributions they each should receive.

If you are not eligible for immediate vesting, the employer contributions do not become your property until the beginning of the 13th month of your employment. You may elect only one investment carrier.

If you do not file a *Carrier Election and Allocation* form, the ABP Administrator will enroll you with the investment carrier selected as the default carrier for the current plan.

You must file an application directly with the investment carrier(s) you have elected or with the default investment carrier if you fail to complete this form. If you fail to do so, you may lose possible revenue from your contributions. Additionally, the carrier(s) you elected will return your contributions to your employer and the ABP administrator will enroll you with the default investment carrier.

### **Information For Vested ABP Members**

ABP members may change their investment carrier election and/or allocation once each quarter of the calendar year.

# RETIREMENT CARRIERS

<u>CARRIER NAME</u>	<u>CONTACT PERSON</u>
<b>VALIC (AIG)</b>	<b>Contact-</b> Diana Carney- <a href="mailto:diana.carney@aig.com">diana.carney@aig.com</a>   <b>Tel:</b> 908-470-4114 <b>Cell:</b> 201-250-4724 <b>Fax:</b> 201-984-4466
<b>AXA Equitable</b>	333 Thornall St., 8th Floor Edison, NJ 08837 <b>Contact:</b> Marc Sheridan- <a href="mailto:Marc.Sheridan@equitable.com">Marc.Sheridan@equitable.com</a> <b>Tel:</b> 908-230-2042 or 732-585-2451 <b>Fax:</b> 732- 906-3629
<b>VOYA (ING)</b> <i>(Default carrier effective August 1, 2021 thru June 30, 2022)</i>	<b>Contact-</b> Dave Ramsumair, CRPC <b>Email:</b> <a href="mailto:d.ramsumair@voyafa.com">d.ramsumair@voyafa.com</a> <b>Tel:</b> (732) 326-5613 <b>Office:</b> (877) 873-0321 <b>Fax:</b> (860) 580-0212
<b>MASS MUTUAL (HARTFORD)</b>	<b>Contact:</b> Yolanda Gonzalez- <a href="mailto:ygonzalez@gittermanwealth.com">ygonzalez@gittermanwealth.com</a> <b>Tel:</b> 848-248-4877 <b>Fax:</b> 888-476-1314 <b>Contact:</b> Ted Kowalchyn <b>email:</b> tkowalchyn@gittermanwealth.com
<b>TIAA/CREF</b>	<b>Contact:</b> Zaki Saoud - <a href="mailto:zaki.saoud@tiaa.org">zaki.saoud@tiaa.org</a> <b>Cell:</b> 201-498-8345 <b>Office:</b> 201-498-8345
<b>METLIFE</b>	David M. Sharpe, Financial Services Representative <b>Contact:</b> David M. Sharpe, Financial Services Representative - <a href="mailto:dsharp2@financialquide.com">dsharp2@financialquide.com</a> <b>Tel:</b> 973-575-3254 <b>Fax:</b> 973-882-7565
<b>PRUDENTIAL RETIREMENT</b>	200 Wood Ave. S, Iselin, NJ 08830 <b>Contact-</b> Alicia Smith - <a href="mailto:alicia.smith@prudential.com">alicia.smith@prudential.com</a> <b>Cell:</b> 732-236-6782 <b>Fax:</b> 1-866-6142-22482



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**DIVISION OF PENSIONS & BENEFITS — BENEFICIARY SERVICES**

P.O. Box 295, Trenton, NJ 08625-0295

**DESIGNATION OF BENEFICIARY —  
ALTERNATE BENEFIT PROGRAM (ABP) /  
DEFINED CONTRIBUTION RETIREMENT PROGRAM (DCRP)**

## **ABOUT THE DESIGNATION OF BENEFICIARY FORM**

This form will replace all prior designations of beneficiary(ies). For more information about your retirement contributions contact your investment carrier.

The *Designation of Beneficiary* form allows a member of a New Jersey Alternate Benefit Program (ABP) or Defined Contribution Retirement Program (DCRP) to nominate a beneficiary, or beneficiaries, for benefits payable upon the death of that member. This form applies to the group life insurance for active and retired members of the ABP or DCRP.

### **GROUP LIFE INSURANCE**

This designation is for any group life insurance benefit payable at the time of your death. Group life insurance does not apply to retirees with less than 10 years of service credit, or members who enrolled at age 60 or older and failed to prove insurability.

### **PRIMARY AND CONTINGENT BENEFICIARIES**

Please be sure to designate both primary and contingent beneficiaries. In the event of your death, the primary beneficiary(ies) will receive any death benefits that are payable. The contingent beneficiary(ies) will receive death benefits only if all primary beneficiaries have predeceased you.

Unless otherwise stated, all beneficiaries will share and share alike. If no primary or contingent beneficiaries survive you, all death benefits will be paid to your estate.

You may nominate any of the following as your primary or contingent beneficiary:

- A person or persons;
- An institution, charity, or corporation; or
- Your estate. Upon your death a court ordered surrogate certificate will be required.

If you choose a distribution of benefits other than the standard share and share alike, or if you are naming a minor, using a trust agreement, acting as a power of attorney for the member, or nominating a civil union partner or domestic partner, please refer to the *Beneficiary Designation* Fact Sheet before completing this form. You may obtain this fact sheet by visiting our website at: [www.nj.gov/treasury/pensions](http://www.nj.gov/treasury/pensions)



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**DIVISION OF PENSIONS & BENEFITS — BENEFICIARY SERVICES**

P.O. Box 295, Trenton, NJ 08625-0295

**DESIGNATION OF BENEFICIARY —  
ALTERNATE BENEFIT PROGRAM (ABP) /  
DEFINED CONTRIBUTION RETIREMENT PROGRAM (DCRP)**

**ORIGINAL FORM MUST BE SUBMITTED IN BLUE INK. ALL REQUESTED INFORMATION MUST BE PROVIDED.  
PLEASE READ AND FOLLOW THE INSTRUCTIONS BEFORE COMPLETING THIS FORM.**

**Contribution Program** (Check one)  ABP  DCRP      **Employment Status** (Check one)  Active  Retired

Print Name \_\_\_\_\_

Mailing Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_\_

Employer Name \_\_\_\_\_

**ACTIVE AND RETIRED GROUP LIFE INSURANCE**

**Primary Beneficiary(ies)** – Receives payment of any and all amounts due upon death.

	BENEFICIARY NAME	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NUMBER
1.	_____	_____	____/____/____	_____
	Address _____			
	<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
2.	_____	_____	____/____/____	_____
	Address _____			
	<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
3.	_____	_____	____/____/____	_____
	Address _____			
	<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>

**Contingent Insurance Beneficiary(ies)** — Receives payment due if primary beneficiary(ies) are deceased.

	BENEFICIARY NAME	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NUMBER
1.	_____	_____	____/____/____	_____
	Address _____			
	<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
2.	_____	_____	____/____/____	_____
	Address _____			
	<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
3.	_____	_____	____/____/____	_____
	Address _____			
	<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>

\_\_\_\_\_

*Member Signature*

*Date*



## INSTRUCTIONS FOR COMPLETING THE DESIGNATION OF BENEFICIARY FORM

**Contribution Program** — Indicate your participation in ABP or DCRP

**Employment Status** — Check the box to indicate if you are an active employee or retired member.

**Member Information** — Print your full name, date of birth, and full Social Security number.

**Employer Name** — Print the name of your active or retired employer location.

**Nominate Your Group Life Insurance Beneficiary** — Print the name of your primary beneficiary(ies) and contingent beneficiary(ies). If this section is not completed, this benefit will automatically default to your estate.

**All members must complete the following** – Make sure to sign, date, and provide your address and daytime telephone number on the form. On any additional sheets used to specify beneficiary information, please be sure to include your signature and date on the sheet, and print your name, address, daytime telephone number, and your full Social Security number.

**Submit completed form to:**                    **New Jersey Division of Pensions & Benefits**  
**ABP/DCRP**  
**P.O. Box 295**  
**Trenton, NJ 08625-0295**

If you have any questions on how to complete your *Designation of Beneficiary* form, send an email to [pensions.nj@treas.nj.gov](mailto:pensions.nj@treas.nj.gov) or visit [www.nj.gov/treasury/pensions](http://www.nj.gov/treasury/pensions)

### DOS AND DON'TS OF BENEFICIARY DESIGNATION

Do complete and submit this original form using only blue ink. Completing this form in pencil or any ink color other than blue makes the form unacceptable. Copies of the *Designation of Beneficiary* form are not accepted.

Do use proper names. Nicknames are not acceptable. When naming a married female as beneficiary, be certain the proper name is given, e.g., Mary J. Jones, not Mrs. John R. Jones.

Do use specific names. The phrase “my children” or “my grandchildren” will not be accepted. You must list each child using his or her specific name.

Do make a copy of your completed *Designation of Beneficiary* form for your records before submitting the original and periodically review it to make sure all beneficiary information is correct. It is especially important to update this information after a life event such as a birth, marriage, divorce, or death.

Don't use a *Designation of Beneficiary* form to update a beneficiary's address. A signed letter notifying us of your beneficiary's address change will suffice. Your letter will be added to your file so your beneficiary information remains current.

Don't use white out or cross out names to make changes in designation. This makes the form unacceptable and a new form will be mailed to you.

Don't name the same person or persons in both the primary and contingent beneficiary sections. This makes the form unacceptable and a new form will be mailed to you.

Before submitting the *Designation of Beneficiary* form, be sure to complete all the items indicated above. Failure to complete this form totally and accurately may jeopardize the payment of your benefits. For any designation not naming a specific person or a share and share alike distribution, please refer to the *Beneficiary Designation* Fact Sheet.