RETIREMENT CHECKLIST

MCBCL 12831 (2-79)

DATE	ALL RETIREMENTS
11-09-82	Application (SF-2801) Signed
11-09-82	Memo to Dept. advising of Employees application
IN / OUT	ERS-9 to Payroll for preliminary SF-2806/2807
	2801, 1084, Preliminary 2806/2807 Comp. to OPM
11-10-82	Retirement Certificate (32 yrs 06 mos)
11-09-82	SF-56 w/cy SF-54 (if any)
11-09-82	SF-2810
01/03/83	SF-56 (w/54), 2801, 1084 2810/2809 (S) to payroll

DATE	DISABILITY
out / in	SF-2801-D, Request for Medical Records (Hospital)
out / in	SF-2801-B, Private Physician Statement
	Ltr to Employee advising of physical exam (if not working)
out / in	Ltr to Fed Med O w/CSC 3178 after receipt of 2801-B
	SF-71, App for leave
	Talked w/emp Supt about possible placement
out / in	SF-2801-A, Superior Officer's Statement
	SF-2801-C to MOB (Boyers, PA) w/encls (cy to DC)
in / out	Approval of Disability rec'd ERS-7, Notice of Approval

Approximate Annuity 14,884 PA

LESS Deposit 32 PA

Survivor Annuity Ded 1,215 PA

Health Benefits Ded 91 pm

Optional FEGLI Ded FREE

Net Annuity 1,045

Suvivor Annuity 681 pm

FEGLI

	yes	no	con't
Regular	☑	☐	☐ 5 years service
Optional	☐	☐	☐ enrolled since first opportunity or for 5 years before retirement

HEALTH BENEFITS

☑ yes ☐ no

☐ 5 years Service

☐ enrolled since first opportunity or for 5 years before retirement

CC# 663101 EC# 102

Type of Retirement: ☑ optional ☐ disability

Annuity: ☑ survivor ☐ life

AGE 55 DOB 11-23-27

Civ Svc 29 Comp Date 06-08-50

Mil Svc 3

Date last worked 30 Dec 82

Sick leave began

Sick leave used past 2 years

Sick and excess Leave expires

All leave expires

ERS 5 to Employment 7373/5988

PERSONAL INFORMATION

NAME Raynor, Gurnan C. PAY NUMBER 2383-05243 SSN 241-36-8601

ADDRESS Route #2, Box 107N. Benlonville, NC 28518 HOME PHONE 919-298-5385

JOB TITLE Wtr Treatment Plt Opr DEPARTMENT Maint

SUPERVISOR MR Price PHONE 2080/5988 DATE ENTERED DEPT 11-18-53

LEAVE

PAY PERIOD ENDING 10/30/82

SICK 2313 ANNUAL 253 CEILING

DATE SEPARATION 01-03-83 ~~12-30-82~~

PREPARED

REMARKS

CSRS

APPLICATION FOR IMMEDIATE RETIREMENT

CIVIL SERVICE RETIREMENT SYSTEM

See Privacy Act Information on back of this form.

Section A -- Identifying Information

1. Name *(Last, first, middle)*		2. List all other names you have used	
RAYNOR, GURMAN C.		None	
3. Address *(Number, street, city, State, Zip Code)*	**4. Telephone Number** *(Including area code)*	**5. Date of birth** *(Month, day, year)*	**6. Social Security Number**
Route #2, Box 107H Beulaville, N.C. 28518	919-298-5385	11-23-27	241-36-8601
7. Are you a citizen of the United States of America?	[X] Yes [ ] No - If "No" give ——→	**7a. Of what country are you a citizen?**	
8. Is this an application for disability retirement?	[X] Yes *(Ask your employing office about other documents you must submit)* [ ] No		

Section B -- Federal Service

1. Department or agency from which you are retiring *(Include Bureau or Division, address and Zip Code)*	2. Date of final separation *(Month, day, year)*
D/Navy, Civilian Personnel Division, MCB, Camp Lejeune, N.C. 28542	01-03-83
	3. Title of last position Water Treatment Plant Operator, WG-10
4. Have you performed active honorable service in the Armed Services or other uniformed services of the United States *(See instructions for definition)?*	[XX] Yes *(Complete Schedule A and attach to this form)* [ ] No
5. Are you receiving or have you applied for military retired pay and/or Veterans Administration pension or compensation in lieu of military retired pay?	[ ] Yes *(Complete Schedule B and attach to this form)* [XX] No

Section C -- Marital Information

1. Are you married now? *(a marriage exists until ended by death, divorce, or annulment)?*		[XXX] Yes *(Also complete items 1a-f below)* [ ] No
1a. Spouse's name *(Last, first, middle)* Raynor, Sarah E.	**1b. Spouse's date of birth** *(Month, day, year)* 09-25-35	**1c. Spouse's Social Security Number** 237-52-9808
1d. Place of marriage *(City, State)* Dillon, SC	**1e. Date of marriage** *(Month, day, year)* 12-12-53	**1f. Marriage performed by:** [x] Clergyman or Justice of the Peace [ ] Other *(Explain):*

Section D -- Annuity Election *(Initial only one of the four boxes below)*

Make your election by initialing the box beside the type of annuity you want to receive and give any other information requested. Read the information on page 3 of the instructions and the explanations below and consider your election carefully. No change will be permitted after your annuity is granted except as explained in the instructions. If you are married at retirement and you do not elect maximum survivor benefits, the law requires that your spouse be informed of your election; therefore, you must attach Standard Form 2801-2 to this form.

1. I CHOOSE A REDUCED ANNUITY WITH SURVIVOR ANNUITY FOR MY SPOUSE EQUAL TO:

You must be married at retirement to choose this type of annuity.

a. Maximum survivor benefits

INITIALS: GCR

55% OF ALL MY ANNUITY

OR

b. Lesser survivor benefits *(If you elect this, attach Standard Form 2801-2)*

INITIALS:

55% OF . . . . . $_____ * A YEAR

*This amount must be less than your yearly annuity.

2. I CHOOSE AN ANNUITY PAYABLE ONLY DURING MY LIFETIME. *(If you are married and elect this, attach Standard Form 2801-2.)*

INITIALS:

All retiring employees may choose this type of annuity. If you are married at retirement, you CANNOT change this election after your annuity is granted and no survivor annuity will be paid to your spouse after your death.

3. I CHOOSE A REDUCED ANNUITY WITH SURVIVOR ANNUITY FOR THE PERSON NAMED BELOW WHO HAS AN INSURABLE INTEREST IN ME.

INITIALS:

You must be single, healthy, and willing to undergo a physical examination if you choose this type of annuity. *(Disability annuitants are not eligible to choose this type of annuity.)*

Name of person with insurable interest	Relationship to you	Date of birth	Social Security Number

Section E — Insurance Information

1. Are you enrolled in the Federal Employees Health Benefits Program?	[XX] Yes [ ] No
2. Are you covered by the Federal Employees' Group Life Insurance Program?	[XX] Yes [ ] No

Section F — Other Claim Information

1. Are you receiving, have you ever received, or have you applied for workers compensation from the Department of Labor because of a job-related illness or injury?	[ ] Yes *(Complete Schedule C and attach to this form)* [XXX] No
2. Have you previously filed any application under the Civil Service Retirement System *(for retirement, refund, deposit or redeposit, or voluntary contributions)*?	[ ] Yes *(Complete items 2a and 2b below)* [XXX] No
2a. Type of application [ ] Retirement [ ] Refund [ ] Deposit or redeposit [ ] Voluntary contributions	2b. Claim numbers

Section G *(Optional)* — Information About Your Unmarried Dependent Children

1. Dependent child's name *(First, middle, last)*	2. Date of birth *(Mo., dy., yr.)*	3. Disabled (✓)	1. Dependent child's name *(First, middle, last)*	2. Date of birth *(Mo., dy., yr.)*	3. Disabled (✓)
Richard E. Raynor	02-12-65				

Section H — Applicant's Certification

WARNING
Any intentional false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)

I hereby certify that all statements made in this application are true to the best of my knowledge and belief.

Signature *(Do not print)*: German C. Raynor

Date: 12-29-82

Applicant's Checklist

This checklist is provided to help you be certain you have attached all necessary documents and to help your employing office be certain it forwards all of your retirement documentation to the Office of Personnel Management.

	Yes	No
1. If you answered "yes" to Section B, item 4, did you attach Schedule A?	X	
2. If you completed Schedule A, did you attach a copy of your discharge certificate or other certificate of active military service?	X	
3. If you answered "yes" to Section B, item 5, did you attach Schedule B?		X
4. If you completed Schedule B and answered "yes" to item 5, did you attach a copy of your request for waiver and a copy of the military finance office's acknowledgement or approval of your request for waiver *(if available)*?		X
5. If you are married and you elected either less than full survivor benefits *(Election 1b)* or an annuity payable only to you you during your lifetime *(Election 2)*, did you attach SF 2801-2, Spouse's Notification of Survivor Election?		X
6. If you answered "yes" to Section F, item 1, did you attach Schedule C?		X

Privacy Act Statement

Solicitation of this information is authorized by the Civil Service Retirement law (Chapter 83, title 5, U.S. Code), the Federal Employees' Group Life Insurance law (Chapter 87, title 5, U.S. Code) and the Federal Employees Health Benefits law (Chapter 89, title 5, U.S. Code). The information you furnish will be used to identify records properly associated with your application, to obtain additional information if necessary, to determine and allow present or future benefits, and to maintain a unique identifiable claim file for you. The information may be shared with national, state, local or other charitable or social security administrative agencies in order to determine benefits under their programs, to obtain information necessary under this program, or to report income for tax purposes. It may also be shared with law enforcement agencies when they are investigating a violation or potential violation of the civil or criminal law. Executive Order 9397 (November 22, 1943) authorizes use of the social security number. Furnishing the social security number, as well as other data, is voluntary, but failure to do so may delay or prevent action on your application. Information you provide about your unmarried dependent children may be used to expedite their claims after you die; however, your failure to supply such information will not affect any future rights they may have to benefits.

SF 2801
Revised January 1982

Schedules A, B and C

1. Name *(Last, first, middle)*	2. Date of birth *(Month, day, year)*	3. Social Security Number
RAYNOR, GURMAN COUNCIL	11-23-27	241-36-8601

Schedule A — Military Service Information

1. If you have performed active honorable service in the Armed Services, or other uniformed services shown below, complete 1a-e below and attach a copy of your discharge certificate or other certificate of active military service *(if available)*.

See instructions for definitions of Armed Services and Uniformed services.

a. Branch or Service	b. Serial Number	c. Dates of Active Duty		d. Last Grade or Rank	e. Organization at Discharge *(Div., Co., etc.)*
		Fr. *(Mo., dy., yr.)*	To *(Mo., dy., yr.)*		
Army	14282059	05-25-48	03-06-50	Cpl	Fort Dix, NJ
Air Force		01-17-52	09-14-53	Airman 2nd Class	Salena, Kansas

Schedule B — Military Retired Pay

1. If you are receiving or have applied for military retired pay, complete parts 1 a-e below.

a. Are you receiving or have you ever applied for military retired or retainer pay?
☐ Yes ☒ No

b. Have you waived all or part of your military retired or retainer pay in order to receive pension or compensation from the Veterans Administration?
☐ Yes ☒ No

c. Was your military retired or retainer pay awarded for reserve service under Chapter 67, title 10?
☐ Yes *(If available, attach a copy of notice of award)* ☐ No

d. Was your military retired or retainer pay awarded for a disability incurred in combat or caused by an instrumentality of war?
☐ Yes *(If available, attach a copy of notice of award)* ☐ No

e. Are you waiving your military retired or retainer pay in order to receive credit for military service for Civil Service retirement benefits?
☐ Yes *(If available, attach a copy of your request for waiver and a copy of military finance officer's acknowledgment or approval of your request for waiver)* ☐ No

Schedule C — Federal Employees Compensation Information

1. Are you receiving or have you ever received workers' compensation from the Office of Workers' Compensation Programs *(OWCP)*, Department of Labor, because of a job-related illness or injury?
☐ Yes *(Complete parts 1a-c below)*
☒ No *(Go to question 2)*

a. Compensation Claim Number	b. Benefit Received		c. Type of Benefit
	Fr. *(Mo., dy., yr.)*	To *(Mo., dy., yr.)*	
			☐ Scheduled award ☐ Total or partial disability compensation
			☐ Scheduled award ☐ Total or partial disability compensation

2. If you have applied for workers' compensation *(Other than as listed in item 1a above)* but are NOT receiving benefits, check reason below and give the information requested. N/A

☐ a. Awaiting OWCP decision	☐ b. Claim denied	
Compensation claim number	Compensation claim number	Date claim denied

3. Except for scheduled compensation awards, workers' compensation and Civil Service retirement benefits CANNOT be paid for the same period of time. Please complete the information below regarding your claim.

a. Do you agree to notify us promptly if the status of your workers' compensation claim changes? ☒ Yes ☐ No

b. Do you authorize the Office of Personnel Management and/or the Office of Workers' Compensation Programs *(OWCP)* to collect any overpayment if we later find you are ineligible for both compensation and annuity payments covering the same period of time? Yes ☒ No ☐

Applicant's Certification

I certify that all statements made on these schedules are true to the best of my knowledge and belief.	Signature *(Do not print)*	Date
	Gurman C. Raynor	11-09-82

Honorable Discharge

from the Armed Forces of the United States of America

This is to certify that

AIRMAN SECOND CLASS GURMAN COUNCIL RAYNER AF 14 282 059

was Honorably Discharged from the

United States Air Force

on the 14TH *day of* SEPTEMBER 1953 . *This certificate is awarded as a testimonial of Honest and Faithful Service*

DONN M. JONES, MAJOR USAF
SEPARATION OFFICER

DD FORM 1 NOV 51 256 AF PREVIOUS EDITIONS OF THIS FORM MAY BE USED.

6/24/86

Mary Turgin
to determine
his limitations

Honorable Discharge

from the Armed Forces of the United States of America

This is to certify that

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Donn M. Jones

DONN M. JONES, MAJOR USAF
SEPARATION OFFICER

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SEPARATION OFFICER

DD FORM 1 NOV 51 256 AF PREVIOUS EDITIONS OF THIS FORM MAY BE USED.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1981-353-064/1604

FEGLI

AGENCY CERTIFICATION OF INSURANCE STATUS

Federal Employees' Group Life Insurance Program

1. Name (Last)	(First)	(Middle)	2. Date of birth (mo., dy., yr.)	3. Social Security Number		
RAYNOR	Gurman	Council	11-23-27	241	36	8601

4. Check the reason for termination of insurance (4a, below) and disposition of current SF 54 or SF 2823, Designation of Beneficiary (4b, below). All SF 54's and SF 2823's, if any, should be attached to this SF 2821 if the employee (a) died, (b) is retiring, or (c) is receiving Federal Employees' Compensation and is entitled to continue life insurance. In all other cases show, whether or not a current SF 54 or SF 2823 is on file in the employee's Official Personnel Folder (or equivalent).

4a. Reason for terminating insurance

- a [ ] Separated *(includes resignation)*
- b [X] Retired
- c [ ] Died as an employee
- d [ ] Died as a reemployed annuitant
- e [ ] End of 12 months non-pay status
- f [ ] Other *(specify)*

4b. Disposition of SF 54's or SF 2823's

- [X] Attached
- [ ] Not on file with this agency
- [ ] On file in employee's Official Personnel Folder

5. Date of Termination *(month, day, year)*	6. Date of Notice of Conversion Privilege (SF 2819) to Employee *(month, day, year)*.	7. Annual basic pay *(not basic insurance amount)* on date in item 5. Convert daily, hourly, piecework, etc. rate to annual rate.	8. Effective date of continuous coverage under FEGLI program
~~12-30-82~~ 01-03-83	~~12-30-82~~ 01-03-83	23,587.20	01-23-55

9. Did employee have Option A—Standard insurance on date in item 5?	Effective date of election	10. Did employee have Option C—Family insurance on date in item 5?	Effective date of election
[X] No [ ] Yes-If "yes" give →		[X] No [ ] Yes-If "yes" give →	

11. Did employee have Option B—Additional insurance on date in item 5?	Effective date of election	Number of multiples of pay on date in item 5.	Lowest number of multiples of pay during last 5 years
[X] No [ ] Yes-If "yes" give →			

12. I CERTIFY THAT THE ABOVE INFORMATION HAS BEEN OBTAINED FROM, AND CORRECTLY REFLECTS, OFFICIAL RECORDS AND THAT THE EMPLOYEE NAMED WAS COVERED BY FEDERAL EMPLOYEES' GROUP LIFE INSURANCE ON THE DATE SHOWN IN ITEM 5.

Personal signature of authorized agency official	Name and address of agency, including zip code
R E Swaney Jr	D/Navy, Civilian Personnel Division Marine Corps Base, Camp Lejeune, N.C. 28542
Typed name of authorized agency official: R. E. SWANEY, JR.	
Title: Assistant Employee Relations Supt	Commercial phone no. with area code: 919-451-1579
	Date: 11-10-82

IMPORTANT INFORMATION

Death within 31 days.—Under certain conditions, life insurance is payable if death occurs within 31 days after an employee's group insurance terminates even though the employee has not applied for conversion. If death occurs within this period, further information concerning possible benefits should be obtained from the agency named in item 12, above.

Continuation of insurance while receiving Federal Employees' Compensation.—See back of this page.

Conversion to an individual policy.—See back of this page.

If you are retiring, your Basic Life insurance (but not accidental death and dismemberment coverage) may be continued if: (a) you retire on an immediate annuity, (b) you do not convert to an individual policy, and (c) you have had it for the 5 years immediately preceding retirement (or, if less than 5 years, since your first opportunity). Generally, any optional insurance you have may be continued if you continue your Basic Life insurance and you have had the option for the 5 years immediately preceding retirement (or, if less than 5 years, since your first opportunity). If you want to continue your Basic Life insurance, complete SF 2818 to elect the type of reduction in coverage that will occur when you reach age 65 (or when you retire if you are already 65). See Standard Form 2818, "Election of Post-Retirement Basic Life Insurance Coverage," for details about continuing life insurance coverage into retirement.

FEGLI

Federal Employees' Group Life Insurance Program

ELECTION OF POST-RETIREMENT BASIC LIFE INSURANCE COVERAGE

A GENERAL INSTRUCTIONS:

- Read the accompanying information carefully
- Type or print in ink
- Return completed form to your employing office

B Fill in identifying information requested below

Name (Last) (First) (Middle)	Date of Birth (Month, day, year)	Social Security Number
RAYNOR, GURMAN COUNCIL	11-23-27	241 36 8601

Employing Department or Agency	Agency Location (City, State, Zip Code)
D/Navy, Civilian Personnel Division	Marine Corps Base, Camp Lejeune, N.C. 28542

C By completing this form, you are choosing the amount of basic life insurance coverage you will have after you reach age 65. If you are already age 65 or older, and you choose the 75% Reduction or the 50% Reduction, that reduction will begin at retirement.

SIGN AND DATE ONE OF THE BOXES BELOW. *(DO NOT SIGN MORE THAN ONE.)* THEN CROSS OUT THE OTHER TWO BOXES. Failure to cross out the two boxes will not invalidate the form.

1 I WANT THE 75% REDUCTION	2 I WANT THE 50% REDUCTION	3 I WANT NO REDUCTION
I WANT THE 75% REDUCTION. I understand that after I reach age 65 (or upon retirement, if I'm older than 65) the amount of my basic insurance coverage will reduce at the rate of 2% per month until it reaches 25% of my basic insurance amount at retirement. I understand that I cannot change my election to a lesser reduction at a later date.	I WANT THE 50% REDUCTION. I understand that after I reach age 65 (or upon retirement, if I'm older than 65) the amount of my basic insurance coverage will reduce at the rate of 1% per month until it reaches 50% of my basic insurance amount at retirement. I understand that the only change I may make at a later date is to the 75% reduction. I authorize deductions to be made from my annuity or compensation to pay the full cost of this additional protection.	I WANT NO REDUCTION. I understand that there will be no reduction in the amount of my basic insurance coverage after I reach age 65 (or upon retirement, if I'm older than 65). I further understand that I cannot later change to the 50% reduction, but can change to the 75% reduction. I authorize deductions to be made from my annuity or compensation to pay the full cost of this additional protection.
Signature *(Do not print)* Gurman C. Raynor	Signature *(Do not print)*	Signature *(Do not print)*
Date 11-09-82	Date	Date

PRIVACY ACT STATEMENT

Public law 96-427, Federal Employees' Group Life Insurance Act of 1980, authorizes the solicitation of this information. The data you furnish will be used to determine the amount of life insurance coverage you have after retirement.

This information may be shared with national, state, local, or other charitable or social security administrative agencies to determine and issue benefits under their programs, or when they are investigating a violation or potential violation of civil or criminal law. Executive Order 9397 (November 22, 1943) authorizes the use of the Social Security Number to distinguish between you and people with similar names. Furnishing your Social Security Number, as well as other data, is voluntary, but failure to do so may result in the inability of your retirement system to provide you the level of insurance protection you want.

FEGLI

DESIGNATION OF BENEFICIARY

Federal Employees' Group
Life Insurance Program

IMPORTANT
Read instructions
on back of duplicate
before filling in this form

INFORMATION CONCERNING THE INSURED:

Name (Last, First, Middle): RAYNOR, GURMAN COUNCIL

Date of birth (Month, Day, year): Nov 23, 1927

Place an "X" in the appropriate box below:

XX	An employee		Retired or an applicant for retirement		Receiving OWCP benefits or an applicant for OWCP benefits

If you are retired or receiving Federal Employees' Compensation, give your "CSA," "CSI," or "X" number

Department or agency in which presently employed (If retired, former department or agency):

Department or agency	Bureau	Division	Location (City, State and ZIP Code)
D/Navy	U. S. Marine Corps	CPO, MCB	Camp Lejeune, NC 28542

I, the individual identified above, canceling any and all previous Designations of Beneficiary under the Federal Employees' Group Life Insurance Program heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any amount of LIFE INSURANCE and ACCIDENTAL DEATH INSURANCE due and payable at my death. I understand that this Designation of Beneficiary will remain in full force and effect, with respect to any amount payable, unless or until canceled by me in writing, or until such time as it is automatically canceled (see regulation "f" on reverse side of duplicate copy).

INFORMATION CONCERNING THE BENEFICIARY OR BENEFICIARIES (SEE EXAMPLES OF DESIGNATIONS):

Type or print first name, middle initial, and last name of each beneficiary	Type or print address (including ZIP Code) of each beneficiary	Relationship	Share to be paid to each beneficiary
Sarah E. Raynor	Route #2, Box 97 Beulaville, NC 28518	wife	40%
Mrs. Eleanor Rae Mobley	Route #2, Box 108 Beulaville, NC 28518	daughter	20%
Billy F. Raynor	9827 Harwell Drive, Apt 1096 Dallas, TX 75220	son	20%
Richard Earl Raynor	Rt #2, Box 97 Beulaville, NC 28518	son	20%

For each type of insurance (Basic Life, Option A—Standard and Option B—Additional): (1) I hereby direct, unless otherwise indicated above, that if more than one beneficiary is named, the share of any beneficiary who may predecease me shall be distributed equally among the surviving beneficiaries, or entirely to the survivor. (2) I understand that this Designation of Beneficiary shall be void if none of the designated beneficiaries is living at the time of my death.

I hereby specifically reserve the right to cancel or change this Designation of Beneficiary at any time without knowledge or consent of the beneficiary.

Date of execution (month, day, year): 3 april 81

Signature of insured: Gurman C. Raynor

WITNESSES TO SIGNATURE *(A witness is ineligible to receive payment as a beneficiary):*

Signature of witness	Number and street	City, State and Zip Code
Sharon A. Ciccocioppo	CPO, MCB	Camp Lejeune, NC 28542
Mary D. Owens	CPO, MCB	Camp Lejeune, NC 28542

PRINT OR TYPE NAME AND ADDRESS (Including ZIP Code) OF INSURED

Mr. Gurman Raynor
Route #2, Box 97
Beulaville, NC 28518

THIS SPACE RESERVED FOR RECEIVING AGENCY

(Indicate date and by whom received)

SEE REVERSE SIDE OF DUPLICATE COPY FOR INSTRUCTIONS ON WHERE TO FILE THESE FORMS.
DO NOT FILE WITH THE OFFICE OF FEDERAL EMPLOYEES' GROUP LIFE INSURANCE.

☆ U.S Government Printing Office 1979-296-379

Office of Personnel Management	FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM **NOTICE OF CHANGE IN HEALTH BENEFITS ENROLLMENT**	2810-113

2383-05243

Part A. - IDENTIFYING DATA

1. NAME (LAST)	(FIRST)	(MIDDLE INITIAL)	2. DATE OF BIRTH	3. CARRIER CONTROL NO.
RAYNOR	GURMAN	C	11-23-27	6631011

4. ADDRESS (INCLUDING ZIP CODE)	5. PAYROLL OFFICE NO.	6. ENROLLMENT CODE NO.
Route #2, Box 107H Beulaville, N.C. 28518	17067001	102
	7. SOCIAL SECURITY NUMBER	8. DATE THIS ACTION BECOMES EFFECTIVE
	241-36-8601	~~30 Dec 82~~ 01-03-83

ONLY THE ITEM WHICH IS CHECKED BELOW AFFECTS YOUR ENROLLMENT. READ THAT ITEM CAREFULLY AND FOLLOW ANY PERTINENT INSTRUCTIONS. KEEP THIS FORM UNLESS YOUR ENROLLMENT IS TERMINATED AND YOU APPLY FOR CONVERSION.

Part B. - TERMINATION

☐ YOUR ENROLLMENT TERMINATES ON THE DATE IN PART A, ITEM 8, ABOVE.

IMPORTANT NOTICE. - You have the right to convert to an individual contract with the carrier of your plan. See Part B. - Termination on the back of this form for information about your extension of coverage and conversion. If you want to convert, fill in the box on the back of this form and send it to your plan within the time limit specified.

Part C. - CHANGE IN PLAN

☐ YOUR ENROLLMENT SHOWN IN PART A, ITEM 6, ABOVE HAS BEEN TERMINATED BECAUSE OF YOUR ENROLLMENT IN ANOTHER PLAN.

Part D. - TRANSFER OUT

☒ YOUR ENROLLMENT CONTINUES BUT IS TRANSFERRED TO YOUR NEW PAYROLL OFFICE (OR RETIREMENT SYSTEM):

Office of Personnel Management
Civil Service Retirement System
Washington, D.C. 20415

(SEE PART D ON THE BACK OF THIS FORM FOR MORE INFORMATION)

Part E. - TRANSFER IN

☐ YOUR NEW PAYROLL OFFICE (OR RETIREMENT SYSTEM) SHOWN IN PART J BELOW HAS ACCEPTED TRANSFER OF YOUR ENROLLMENT AND WILL CONTINUE IT.

Part F. - REINSTATEMENT

☐ YOUR ENROLLMENT, HAS BEEN REINSTATED, EFFECTIVE ON THE DATE IN PART A, ITEM 8, ABOVE.

Part G. - CHANGE IN NAME OF ENROLLEE

☐ THE NAME IN WHICH THIS ENROLLMENT IS CARRIED HAS BEEN CHANGED TO:

NAME	DATE OF BIRTH	SEX
		MALE ☐ FEMALE ☐
ADDRESS (INCLUDING ZIP CODE) IF DIFFERENT FROM PART A, ITEM 4, ABOVE.		

Part H. - CHANGE IN ENROLLMENT - SURVIVOR ANNUITANT

☐ YOUR ENROLLMENT HAS BEEN CHANGED FROM FAMILY COVERAGE TO SELF ONLY. YOUR PLAN WILL SEND YOU A NEW IDENTIFICATION CARD.

YOUR NEW ENROLLMENT CODE NUMBER ☐

(NOTE: THIS ITEM TO BE COMPLETED BY RETIREMENT SYSTEMS ONLY)

Part I. - REMARKS

OPTIONAL RETIREMENT

Part J. - DATE OF NOTICE

NAME OF AGENCY AND ADDRESS, INCLUDING ZIP CODE	NOTE: Instructions for Employing Offices are on the back of the Quadruplicate copy of this form.
D/Navy, Civilian Personnel Division, Marine Corps Base Camp Lejeune, N.C. 28542	
SIGNATURE OF AUTHORIZED AGENCY OFFICIAL: R E Burnett	DATE: 11-10-82

2810-113

Standard Form No. 2810