

DESIGNATION OF RETIREMENT SYSTEM-TIER-PLAN-BENEFICIARY

PLEASE PRINT OR TYPE

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
RETIREMENT & BENEFIT SERVICES DIVISION

CO-931 REV 7/98 570-01

CHECK TYPES OF ACTIONS BEING SUBMITTED ON THIS FORM - THEN CONSULT APPLICABLE INSTRUCTIONS

NEW EMPLOYEE RE-EMPLOYED AGENCY TRANSFER EMPLOYEE NAME AND ADDRESS CHANGE CHANGE IN BENEFICIARY(IES) NAME AND/OR ADDRESS CHANGE IN RETIREMENT SYSTEM INFORMATION ONLY

I. EMPLOYEE INFORMATION

| | | | | | |
|---|------------------------------------|---|--------------------------|----------------------------------|--|
| EMPLOYEE NAME (Last, First, M.I.) (1) | SOCIAL SECURITY NUMBER (2) | EMPLOYEE NUMBER(3) | DATE OF EMPLOYMENT (4) | DATE OF BIRTH (5) | SEX (6) <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| EMPLOYEE'S HOME ADDRESS (Street No., Name) (City, State, Zip Code) (7) | XXXX-XX - _____ | | | | |
| EMPLOYING AGENCY (11) Western Connecticut State University | MSA P/R LEVEL 2 (11a) HY | AGENCY ADDRESS (12) 181 White Street, Danbury, CT 06810 | | | |
| DATE THE EMPLOYEE WORKED FOR THE STATE BEFORE? (14) <input type="checkbox"/> YES <input type="checkbox"/> NO (If Yes Complete Boxes 15,16,17) | NAME OF AGENCY (15) | | DATE OF TERMINATION (16) | FORMER NAME (if applicable) (17) | |

II. RETIREMENT INFORMATION

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| RETIREMENT SYSTEM(18) | <input type="checkbox"/> ALTERNATE RETIREMENT PROGRAM (b) | <input type="checkbox"/> JUDGES, FAMILY SUPP. MAGISTRATES & COMP. COMM. (c) | <input type="checkbox"/> PROBATE COURT JUDGES & EMPLOYEES (d) | <input type="checkbox"/> PUBLIC DEFENDERS (e) | <input type="checkbox"/> STATES ATTORNEY (f) | <input type="checkbox"/> TEACHERS RETIREMENT SYSTEM (g) | <input type="checkbox"/> OTHER (specify) (h) |
| TIER (State Employees Only) (19) TIER I <input type="checkbox"/> TIER II <input type="checkbox"/> TIER II A <input type="checkbox"/> | TIER I RETIREMENT PLAN (20) PLAN B <input type="checkbox"/> PLAN C <input type="checkbox"/> | RETIREMENT CODE (21) ? | BARG. UNIT (22) 21 | COMP CLASS CODE (23) 7839 | EMPLOYMENT STATUS (24) <input checked="" type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME | TYPE STATUS (25) <input checked="" type="checkbox"/> TEMPORARY <input type="checkbox"/> DURATIONAL <input type="checkbox"/> PERMANENT <input type="checkbox"/> INTERMITTENT | |
| INSURANCE COMPANY / CARRIER (ALTERNATE RETIREMENT PROGRAM ONLY) (26a) | | DEDUCTIONS TO START (26b) | <input type="checkbox"/> IMMEDIATELY <input type="checkbox"/> WITHIN 6 MONTHS | DATE DEDUCTIONS TO START (26c) | | | |

III. BENEFICIARY INFORMATION

If there are more than (4) beneficiaries designated, check the box to the right and attach an additional CO-931 form listing additional beneficiaries

| | | | | |
|--|-----------------------------|--|-------------------------------------|-----------------------------|
| NAME OF BENEFICIARY (Last, First, M.I.) (27) | SOCIAL SECURITY NUMBER (28) | NAME OF BENEFICIARY (Last, First, M.I.) (27) | Contingent <input type="checkbox"/> | SOCIAL SECURITY NUMBER (28) |
| ADDRESS (Street No., Name) (29) | RELATIONSHIP (30) | ADDRESS (Street No., Name) (29) | | RELATIONSHIP (30) |
| (City, State, Zip Code) (31) | PERCENT (32) | DATE OF BIRTH (33) | (City, State, Zip Code) (31) | PERCENT (32) |
| NAME OF BENEFICIARY (Last, First, M.I.) (27) | SOCIAL SECURITY NUMBER (28) | NAME OF BENEFICIARY (Last, First, M.I.) (27) | Contingent <input type="checkbox"/> | SOCIAL SECURITY NUMBER (28) |
| ADDRESS (Street No., Name) (29) | RELATIONSHIP(30) | ADDRESS (Street No., Name) (29) | | RELATIONSHIP (30) |
| (City, State, Zip Code) (31) | PERCENT (32) | DATE OF BIRTH (33) | (City, State, Zip Code) (31) | PERCENT (32) |

IV. MEMBER'S STATEMENT:

I understand the provisions of the retirement plan and that, if applicable, I will be required to make contributions based upon my retirement plan designation. Further, I hereby revoke all previous appointments of beneficiaries made by me, if any, and designate the person(s) named above as beneficiary(ies) such person(s) to receive upon my death any and all sums due me from the Retirement system of which I am a member. This designation shall remain in effect unless I subsequently change it by written notice to the Retirement & Benefit Services Division.

| | | | | |
|---------------------------|-----------|---|------------|-----------|
| EMPLOYEE'S SIGNATURE (34) | DATE (35) | AUTHORIZED AGENCY SIGNATURE (& TITLE)(36) | PHONE (37) | DATE (38) |
| | | | | |