

CHECK TYPES OF ACTIONS BEING SUBMITTED ON THIS FORM - THEN CONSULT APPLICABLE INSTRUCTIONS
 NEW EMPLOYEE RE-EMPLOYED AGENCY TRANSFER EMPLOYEE NAME AND ADDRESS CHANGE
 MULTIPLE EMPLOYMENT OR ADDRESS CHANGE NAME AND/OR ADDRESS CHANGE CHANGE IN BENEFICIARY(IES) CHANGE IN RETIREMENT SYSTEM INFORMATION ONLY

I. EMPLOYEE INFORMATION

EMPLOYEE NAME (Last, First, M.I.) (1) XXXX-XX-____ SOCIAL SECURITY NUMBER (2) _____ EMPLOYEE NUMBER(3) _____ DATE OF EMPLOYMENT (4) _____ DATE OF BIRTH (5) _____ SEX (6) MALE FEMALE

EMPLOYING AGENCY (11) _____ EMPLOYEE'S HOME ADDRESS (Street No., Name) (City, State, Zip Code) (7) _____ MSA P/R LEVEL 2 AGENCY ADDRESS (12) _____ DATE OF MARRIAGE (9) _____ NAME OF SPOUSE (10) _____

EMPLOYING AGENCY (11) Western Connecticut State University (11a) HY 181 White Street, Danbury, CT 06810 NAME OF AGENCY (15) _____ IS THIS EMPLOYEE CURRENTLY (13) EMPLOYED BY ANOTHER AGENCY? YES NO
If yes, provide MSA P/R Level 2 _____ DATE OF TERMINATION (16) _____ FORMER NAME (if applicable) (17) _____

DATE OF TERMINATION (16) _____ FORMER NAME (if applicable) (17) _____

II. RETIREMENT INFORMATION

RETIREMENT SYSTEM(18) _____

STATE EMPLOYEES (a) ALTERNATE RETIREMENT (b) PROGRAM JUDGES, FAMILY SUPP. MAGISTRATES & COMP. COMM. (c) EMPLOYEES (d) PROBATE COURT JUDGES & EMPLOYEES (d) PUBLIC DEFENDERS ATTORNEY (f) TEACHERS RETIREMENT SYSTEM (g) OTHER (specify) (h)

TIER (State Employees Only) (19) TIER I TIER II TIER II A TIER I RETIREMENT PLAN (20) PLAN B PLAN C RETIREMENT CODE (21) BARG UNIT (22) 21 COMP CLASS CODE (23) 7839 EMPLOYMENT STATUS (24) TEMPORARY PERMANENT DURATIONAL INTERMITTENT

CHECK BOX IF HAZARDOUS DUTY Q DEDUCTIONS TO START (26a) _____ IMMEDIATELY WITHIN 6 MONTHS _____ DATE DEDUCTIONS TO START (26c) _____

INSURANCE COMPANY / CARRIER (ALTERNATE RETIREMENT PROGRAM ONLY) (26a) _____ DEDUCTIONS TO START (26b) _____ IMMEDIATELY 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)	Contingent <input type="checkbox"/>	SOCIAL SECURITY NUMBER (28)	RELATIONSHIP (30)	NAME OF BENEFICIARY (Last, First, M.I.) (27)	Contingent <input type="checkbox"/>	SOCIAL SECURITY NUMBER (28)	RELATIONSHIP (30)
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)	DATE OF BIRTH (33)
NAME OF BENEFICIARY (Last, First, M.I.) (27)	Contingent <input type="checkbox"/>	SOCIAL SECURITY NUMBER (28)	RELATIONSHIP (30)	NAME OF BENEFICIARY (Last, First, M.I.) (27)	Contingent <input type="checkbox"/>	SOCIAL SECURITY NUMBER (28)	RELATIONSHIP (30)
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)	DATE OF BIRTH (33)

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) _____

DISTRIBUTION: WHITE - Retirement & Benefit Services Division CANARY - Employee PINK - Retained by Agency