

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
 MULTIPLE EMPLOYMENT

I. EMPLOYEE INFORMATION

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

EMPLOYEE'S HOME ADDRESS (Street No., Name) (City, State, Zip Code) (7) 181 White Street, Danbury, CT 06810 AGENCY ADDRESS (12) MSA P/R LEVEL 2 (11a) HY NAME OF AGENCY (15) 181 White Street, Danbury, CT 06810 DATE OF MARRIAGE (9) NAME OF SPOUSE (10) IS THIS EMPLOYEE CURRENTLY EMPLOYED BY ANOTHER AGENCY? YES NO If yes, provide MSA P/R Level 2 _____ DATE OF TERMINATION (16) FORMER NAME (if applicable) (17)

EMPLOYING AGENCY (11) Western Connecticut State University

AS THE EMPLOYEE WORKED FOR THE STATE BEFORE? (14) YES NO (If Yes Complete Boxes 15,16,17)

II. RETIREMENT INFORMATION

RETIREMENT SYSTEM(8) STATE EMPLOYEES (a) ALTERNATE RETIREMENT PROGRAM (b) JUDGES, FAMILY SUPP. MAGISTRATES & COMP. COMM. (c) PROBATE COURT JUDGES & EMPLOYEES (d) PUBLIC DEFENDERS (e) STATES 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) CODE (23) 21 7839 EMPLOYMENT STATUS (24) TEMPORARY PERMANENT DURATIONAL INTERMITTENT

CHECK BOX IF HAZARDOUS DUTY 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)	SOCIAL SECURITY NUMBER (28)	RELATIONSHIP (30)	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)	NAME OF BENEFICIARY (Last, First, M.I.) (27)	Contingent <input type="checkbox"/>	SOCIAL SECURITY NUMBER (28)
(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)	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)	NAME OF BENEFICIARY (Last, First, M.I.) (27)	Contingent <input type="checkbox"/>	SOCIAL SECURITY NUMBER (28)
(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) _____