

CHANGING BENEFICIARIES

As employees experience family status changes (i.e., birth of a child, marriage, divorce) throughout the course of their employment, they may also want to consider changing their beneficiaries for their retirement plan, group life insurance, and/or supplemental retirement plan(s).

In order to change your beneficiaries, the following must be done:

Group Life Insurance: Employees enrolled in the Group Life Insurance plan must complete a Beneficiary Change Form. This form can be obtained by contacting the Benefits Unit at (860) 679-2791 if your last name begins with the letters A-K or (860) 679-3549 if your last name begins with the letters L-Z.

State Employees Retirement System: Members of the State Employees Retirement System (Tier I, Tier II, or Tier IIA) must complete a new **CO-931** form. This form can be downloaded at the following address: http://employ.uchc.edu/ppf/forms/pdfs/form_co931rev.pdf or can be obtained by contacting the Benefits Unit at (860) 679-2901.

Alternate Retirement Program: Members of the Alternate Retirement Program must complete two separate forms*:

- **ING Beneficiary Form** - The ING Beneficiary Form can be obtained by contacting ING at 1-800-584-6001, or from the following address: http://employ.uchc.edu/ppf/forms/pdfs/form_ctbeneficiaryform.pdf
- **CO-931** - In addition to retirement beneficiaries, the state requires a separate form, CO-931, which is for payroll purposes. It is completed upon hire, and should be updated any time beneficiary changes are made. The last regular paycheck and accruals that are due in the event of death are directed to the beneficiary listed on the CO-931. This form can be downloaded at the following address: http://employ.uchc.edu/ppf/forms/pdfs/form_co931rev.pdf or can be obtained by contacting the Benefits Unit at (860) 679-2901.

403(b): Employees enrolled in a 403(b) plan must contact ING at 1-800-584-6001 to obtain the Beneficiary Form. Please note that this form is not available online.*

457: Employees enrolled in a 457 plan must contact ING at 1-800-584-6001 to obtain the Beneficiary Form. Please note that this form is not available online.*

*** ING Change-Over for the Alternate Retirement Program, 403(b), and 457:**

During the change-over to ING as the administrator of the Alternate Retirement Program and the two supplemental retirement plans, (403(b) and 457) employees were asked to complete new beneficiary forms. Please be advised that if you made beneficiary changes at that time, the changes only apply to funds that have been payroll deducted and sent to ING, or funds that have been rolled-over from other companies to ING. If you still have funds with other companies, such as TIAA-CREF, the beneficiary form that is on file with that company is the form that applies to those funds. To update this beneficiary information you must contact the company directly:

Former Alternate Retirement Program Vendor:

Financial Services Organization	Contact Number	Internet
TIAA-CREF	(800) 842-2776	http://www.tiaa-cref.org

Former 403(B) Vendors:

Financial Services Organization	Contact Number	Internet
Fidelity Investments	(800) 343-0860	https://www.fidelity.com
The Hartford Life Insurance Company	(800) 528-9009	http://www.thehartford.com
ING Life Insurance and Annuity Company	(800) 784-6386	http://www.ing-usa.com
Oldham Resource Group	(800) 626-6106	http://www.oldhamresourcegroup.com
TIAA-CREF	(800) 842-2888	http://www.tiaa-cref.org
Travelers Life & Annuity	(800) 842-4015 Press option2	http://www.metlife.com

Former 457 Vendors:

Financial Services Organization	Contact Number	Internet
ING	(800) 262-3862	http://www.ingretirementplans.com
The Hartford	(888) 457-7824	http://www.retire.hartfordlife.com
Phoenix	(800) 541-0171 (Group Annuity) (800) 243-1574 (Mutual Funds)	http://www.PhoenixInvestments.com

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

NEW EMPLOYEE RE-EMPLOYED, AGENCY TRANSFER EMPLOYEE NAME AND OR 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)				MARITAL STATUS (8) <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	DATE OF MARRIAGE (9)	NAME OF SPOUSE (10)
EMPLOYING AGENCY (11)	MSA P/R LEVEL 2 (11a)	AGENCY ADDRESS (12)			IS THIS EMPLOYEE CURRENTLY (13) EMPLOYED BY ANOTHER AGENCY? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, provide MSA P/R Level 2 _____	
HAS 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"/> STATE EMPLOYEES (a)	<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) <input type="checkbox"/> TIER I <input type="checkbox"/> TIER II <input type="checkbox"/> TIER II A CHECK BOX IF HAZARDOUS DUTY <input type="checkbox"/>	TIER I RETIREMENT PLAN (20) <input type="checkbox"/> PLAN B <input type="checkbox"/> PLAN C	RETIREMENT CODE (21)	BARG. UNIT (22)	COMP CLASS CODE (23)	EMPLOYMENT STATUS (24) <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME	TYPE STATUS (25) <input 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) 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)	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)	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) 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)
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