

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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