

DESIGNATION OF RETIREMENT SYSTEM-TIER-PLAN-BENEFICIARY

CO-931 REV 7/98 570-01A

PLEASE PRINT OR TYPE

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

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

NEW EMPLOYEE RE-EMPLOYED, MULTIPLE EMPLOYMENT 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)
EMPLOYEE'S HOME ADDRESS (Street No., Name) (City, State, Zip Code) (7)				MARITAL STATUS (8)	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)		
CAPITAL COMMUNITY COLLEGE		CCC79300	950 Main St, Hartford, CT 06103	EMPLOYED BY ANOTHER AGENCY? <input type="checkbox"/> YES <input type="checkbox"/> NO		
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)

STATE EMPLOYEES (a) ALTERNATE RETIREMENT PROGRAM 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 PLAN A PLAN B PLAN C

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)	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)	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"/>
ADDRESS (Street No., Name) (29)	RELATIONSHIP (30)	ADDRESS (Street No., Name) (29)	RELATIONSHIP (30)	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) **Payroll**

PHONE (37) **(860) 906-500**

DATE (38) _____