**DESIGNATION OF RETIREMENT SYSTEM-TIER-PLAN-BENEFICIARY**

CO-931 REV. 7/98

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) ☐ MALE ☐ FEMALE |
|---|---|---|---|---|---|
| | | | | | |

| EMPLOYEE'S HOME ADDRESS (Street No., Name) (City, State, Zip Code) (7) | MARITAL STATUS (8) ☐ SINGLE ☐ 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 EMPLOYED BY ANOTHER AGENCY? (13) If yes, provide MSA P/R Level 2 _____ ☐ YES ☐ NO |
|---|---|---|---|
| | | | |

| HAS THE EMPLOYEE WORKED FOR THE STATE BEFORE? (14) ☐ YES ☐ 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 (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 (i)

| TIER (State Employees Only) (19) ☐ TIER I ☐ TIER II ☐ TIER IIA CHECK BOX IF HAZARDOUS DUTY ☐ | TIER I RETIREMENT PLAN (20) ☐ PLAN B ☐ PLAN C | RETIREMENT CODE (21) | BARG UNIT (22) | COMP CLASS CODE (23) | EMPLOYMENT STATUS (24) ☐ FULL TIME ☐ PART TIME | TYPE STATUS (25) ☐ TEMPORARY ☐ PERMANENT ☐ DURATIONAL ☐ INTERMITTENT |
|---|---|---|---|---|---|---|
| | | | | | | |

| 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 ☐ | 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 ☐ | SOCIAL SECURITY NUMBER (28) | NAME OF BENEFICIARY (Last, First, M.I.) (27) Contingent ☐ | 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) |
|---|---|---|---|---|
| | | | | |

DISTRIBUTION: - Retirement & Benefit Services Division - Employee - Agency