DESIGNATION OF RETIREMENT PLAN ELECTION
Higher Education Employment Only
CO-931h Rev. 9/2017

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
RETIREMENT SERVICES DIVISION

General Instructions: This form is to be completed for all employees hired in an institution of higher education or the board of higher education central office only.

This form must be completed by the employing agency in conjunction with the employee, signed by both the employee and agency staff in Section IV and returned to the Retirement Services Division as soon as possible following the individual's employment date or effective date of any change.

CHECK TYPES OF ACTIONS BEING SUBMITTED ON THIS FORM

☐ **NEW EMPLOYEE** ☐ **RE-EMPLOYED** ☐ **MULTIPLE EMPLOYMENT** ☐ **AGENCY TRANSFER** ☐ **TRANSFER TO OR FROM HAZARDOUS DUTY** ☐ **CHANGE IN RETIREMENT ELIGIBILITY STATUS**

I. EMPLOYEE PERSONAL INFORMATION

LAST NAME	FIRST NAME	M.I.	EMPLOYEE NO.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER MALE ☐ FEMALE ☐

ADDRESS (Street No., Name) (City, State, Zip Code)

MARITAL STATUS	DATE OF MARRIAGE	NAME OF SPOUSE
MARRIED ☐ SINGLE ☐		

DO YOU HAVE A PENSION DIVISION ORDER ("QDRO") AS A RESULT OF DIVORCE/LEGAL SEPARATION? YES ☐ NO ☐

IF YES, HAS THE ORDER BEEN SUBMITTED TO AND ACCEPTED BY THE RETIREMENT SERVICES DIVISION? YES ☐ NO ☐

II. EMPLOYMENT INFORMATION

EMPLOYING AGENCY	RECORD NUMBER	AGENCY ADDRESS
UConn		9 Walters Ave. Storrs, CT 06269

EMPLOYMENT DATE/EFFECTIVE DATE	BARG UNIT	CORE-CT JOB CODE	EMPLOYMENT STATUS	TYPE STATUS
			Full-time ☐ Part-time ☐	Permanent ☐ Temporary ☐ Durational ☐ Intermittent ☐

IS EMPLOYEE CURRENTLY EMPLOYED WITH ANOTHER STATE AGENCY? YES ☐ NO ☐ If YES, provide Agency Name

HAS EMPLOYEE WORKED FOR THE STATE BEFORE? YES ☐ NO ☐ If YES, provide Agency Name and termination date

III. RETIREMENT INFORMATION

As a condition of employment with the State of Connecticut, all faculty and staff members must participate in a retirement plan with the exception of part-time Adjunct Faculty members. Part-time Adjunct Faculty members may elect to waive retirement plan membership.

Classified employees in higher education automatically become members of the State Employees Retirement System (SERS).

Unclassified employees must make a **one-time irrevocable election** of retirement plan membership. **Serious consideration must be given to the election of a retirement plan, as it is an irrevocable decision. Election must be made by the first day of employment. The proper retirement plan contributions must be deducted from the employee's first paycheck.**

Special note: If you elect the ARP, Hybrid or TRS and are subsequently employed in a position ineligible for participation in these plans, you will automatically begin participation in SERS.

See page 2 for retirement plan election choices.

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Please review Retirement Options for Higher Education employees on the OSC website at osc.ct.gov.
Please indicate your irrevocable retirement plan election below.

☐ Option 1 - State Employees Retirement System

(select applicable Tier) ☐ Tier I ☐ Tier II ☐ Tier IIA ☐ Tier III ☐ Tier IV

Hazardous Duty? ☐ Yes ☐ No

☐ Option 2 - Alternate Retirement Program (ARP)

☐ Employee contribution 5%

or

☐ Employee contribution 6.5% (default)

☐ Option 3 - State Employees Retirement System Hybrid Plan (Hybrid)

☐ Option 4 - Teachers Retirement System (TRS)

☐ Option 5 - Waiver (part-time adjuncts only)

☐ Ineligible for retirement plan membership Reason: _____

IV. MEMBER'S STATEMENT

Please note: If this form is not received by your Human Resources office by the first day of employment, you will be defaulted into a retirement plan based on your bargaining unit. This default is irrevocable.

I understand that this is an irrevocable decision, and I cannot, at a later date, choose to participate in another plan.

EMPLOYEE'S SIGNATURE	EMPLOYEE NUMBER	DATE
AUTHORIZED AGENCY SIGNATURE (& TITLE)	PHONE	DATE
	860-486-3034	

Forward completed form to: Retirement Services Division, Customer Service Center, 55 Elm Street, Hartford, CT 06106. Agency should retain one copy and provide one copy to employee.

This form must be accompanied by Form CO-999 "Designation of Retirement Plan Beneficiary".

DESIGNATION OF RETIREMENT PLAN BENEFICIARY FORM FOR ACTIVE/INACTIVE MEMBERS

CO-999 6/2018

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
RETIREMENT SERVICES DIVISION

I. EMPLOYEE PERSONAL INFORMATION

MEMBER STATUS: NEW MEMBER ☐ ACTIVE MEMBER ☐ INACTIVE MEMBER ☐

INACTIVE MEMBERS (ONLY):
NEW ADDRESS ☐ NAME CHANGE ☐

LAST NAME	FIRST NAME	M.I.	EMPLOYEE NO.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER MALE ☐ FEMALE ☐

ADDRESS (Street No., Name) (City, State, Zip Code)

MARITAL STATUS	DATE OF MARRIAGE	NAME OF SPOUSE
MARRIED ☐ SINGLE ☐		

II. BENEFICIARY DESIGNATION

- Type or PRINT clearly.
- You may name any living person, your estate, a trust, or a charitable organization as your beneficiary.
- At least one beneficiary must be named. If more than one primary beneficiary is named, the share of the beneficiary who dies before you shall be divided equally among the surviving beneficiaries.
- A payment is made to a contingent beneficiary(ies) only if all primary beneficiaries die before you do.
- If you survive all of the beneficiaries named, payment would be made to your estate.
- To designate a trust as beneficiary enter the name and date of the trust agreement in the Beneficiary section of this form; leave the Relationship and Social Security sections blank; and indicate Primary or Contingent.
- To designate your estate as beneficiary enter the word "Estate" in the beneficiary section of this form; leave the Relationship and Social Security sections blank; indicate Primary or Contingent.

Primary beneficiary(ies) must equal 100%. Contingent beneficiary(ies) must equal 100%. Please use whole percentages. If there are more than (4) beneficiaries designated, check the box to the right and attach an additional CO-999 form listing additional beneficiaries. ☐

NAME OF BENEFICIARY PRIMARY ☐			SOCIAL SECURITY NUMBER	NAME OF BENEFICIARY PRIMARY ☐ CONTINGENT ☐			SOCIAL SECURITY NUMBER
Last Name	First Name	M.I.		Last Name	First Name	M.I.	
ADDRESS (Street No., Name)			RELATIONSHIP	ADDRESS (Street No., Name)			RELATIONSHIP
(City, State, Zip Code)		PERCENT	DATE OF BIRTH	(City, State, Zip Code)		PERCENT	DATE OF BIRTH

NAME OF BENEFICIARY PRIMARY ☐ CONTINGENT ☐			SOCIAL SECURITY NUMBER	NAME OF BENEFICIARY PRIMARY ☐ CONTINGENT ☐			SOCIAL SECURITY NUMBER
Last Name	First Name	M.I.		Last Name	First Name	M.I.	
ADDRESS (Street No., Name)			RELATIONSHIP	ADDRESS (Street No., Name)			RELATIONSHIP
(City, State, Zip Code)		PERCENT	DATE OF BIRTH	(City, State, Zip Code)		PERCENT	DATE OF BIRTH

III. MEMBER'S STATEMENT

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 Services Division.

EMPLOYEE'S SIGNATURE	DATE	
AUTHORIZED AGENCY SIGNATURE (& TITLE)	PHONE 860-486-3034	DATE

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