DESIGNATION OF RETIREMENT PLAN BENEFICIARY

CO-999 9/2017

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
RETIREMENT SERVICES DIVISION

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. BENEFICIARY DESIGNATION

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	DATE

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.