Personal Information Change Request
Governmental 457(b) Plan

Use black or blue ink when completing this form. Only participants who have terminated employment with this employer may use this form. If I am still employed, I need to contact my Employer to make changes to my account. For questions regarding this form, visit the Web site at www.louisianadcp.com or contact Service Provider at 1-800-701-8255.

Louisiana Public Employees Deferred Comp. Plan **98228-01**

A Participant Information *(Provide Name, Social Security Number and Date of Birth as it currently appears on the account)*

Account extension identifies funds transferred to a beneficiary due to death, alternate payee due to divorce or a participant with multiple accounts.

___________________ Account Extension

☐☐☐ - ☐☐ - ☐☐☐☐ Social Security Number *(Must provide all 9 digits)*

Last Name First Name M.I. Date of Birth ____/____/____

I have a retirement savings account with a previous employer or an IRA. ❑ Yes or ❑ No

I would like help consolidating my other retirement accounts into my account with State of Louisiana.* ❑ Yes, I would like a representative to call me at phone #_______-_______-_______ to review my options and assist me with the process. The best time to call is _______ to _______ A.M./ P.M. (circle one - available 8:00 A.M. to 6:00 P.M. MST). *Rollovers are subject to my Plan's provisions.

B Name Change *(Attach a copy of birth certificate, divorce decree, marriage certificate, military ID, passport or court order)*

Last Name First Name M.I.

Address and/or Contact Information Change

Street Address City/State/Zip Code

(   ) Daytime Phone Number (   ) Alternate Phone Number Email Address

Personal Information Change

Date of Birth ____/____/____ *(Attach a copy of Birth Certificate)*

Change of Status: ❑ Married ❑ Unmarried ❑ Female ❑ Male

Social Security Number Change *(If I am still employed, I must obtain approval from my Employer)*

Social Security Number ____________________ *(Attach a signed copy of Social Security Card)*

C Signatures and Consent *(Signatures must be on the lines provided.)*

Participant Consent *(Please sign on the 'Participant Signature' line below.)*

I affirm that the information I have provided on this form is true and correct.

Any person who presents a false or fraudulent claim is subject to criminal and civil penalties.

Participant Signature ______________________ **Date *(Required)*** __________

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Authorized Plan Administrator Signature *(Required for Social Security Number changes only)*

(Please sign on the 'Authorized Plan Administrator Signature' line below.)

I certify and accept that the information provided by the participant on this form is correct.

Authorized Plan Administrator Signature ______________________ **Date *(Required)*** __________

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Print Full Name ______________________

Last Name	First Name	M.I.	Social Security Number	98228-01 Number

D Mailing Instructions

After all signatures have been obtained, this form can be sent by

Fax to: **1-866-745-5766**	**OR**	**Regular Mail to:** State of Louisiana PO Box 173764 Denver, CO 80217-3764	**OR**	**Express Mail to:** State of Louisiana 8515 E. Orchard Road Greenwood Village, CO 80111

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