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.milwaukeecounty457.com or contact Service Provider at 1-877-457-6459.

Milwaukee County Deferred Compensation Plan **98442-01**

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 plan with a previous employer or an IRA. ❑ Yes or ❑ No

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)*** _____

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)*** _____

Last Name	First Name	M.I.	Social Security Number	98442-01 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:
Empower Retirement
PO Box 173764
Denver, CO 80217-3764

OR

Express Mail to:
Empower Retirement
8515 E. Orchard Road
Greenwood Village, CO 80111

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