UNIVERSITY OF Cincinnati

ALTERNATIVE RETIREMENT PLAN PROVIDER CHANGE REQUEST FORM

As a participant in the Ohio Alternative Retirement Plan (ARP) at the University of Cincinnati, you are eligible to change your ARP provider at any time during the year. Your change request will be effective based upon receipt in UC HR and payroll processing deadlines.

Section I – Personal Information (Please print legibly)

Name: _____ Employee ID: _____

Email Address: _____ Social Security #: _____

Effective Date (*choose one*): Daytime Telephone #: _____

☐ Next available payroll period

☐ Effective date (must be a future date): _____

Section II - Election

My current ARP provider is:

☐ AXA/Equitable Life Insurance Company
☐ Fidelity Investments.
☐ Great American Life Insurance Company
☐ ING Financial Services
☐ Lincoln National Life Insurance Company
☐ Metropolitan Life Insurance Company
☐ Nationwide Life Insurance Company
☐ TIAA-CREF
☐ VALIC

If you change ARP providers, state legislation allows you to transfer a portion or all of your existing ARP balance to the new provider. Account transfers may be temporarily restricted based on account type. You must contact your new provider to establish the account and to arrange for any desired transfer of your current account balance. Change will be effective based on receipt in UC HR and payroll processing deadlines.

☐ I elect the ARP provider indicated below. I understand it is my responsibility to establish an account and arrange for any desired transfer of existing account balances.

☐ AXA/Equitable Life Insurance Company
☐ Fidelity Investments
☐ Great American Life Insurance Company
☐ ING Financial Services
☐ Lincoln National Life Insurance Company
☐ Metropolitan Life Insurance Company
☐ Nationwide Life Insurance Company
☐ TIAA-CREF
☐ VALIC

Contact information for the ARP providers is available at www.uc.edu/hr/benefits/retirement/plans.

Section III – Authorization

I hereby certify the election chosen above in Section II. This election to change providers shall remain in full force and effect while I am employed by the University of Cincinnati and/or until a new provider election is made.

Signature: _____ Date: _____

Retain a copy for your records. Return the ORIGINAL of this form to:
UC Human Resources, Benefits Department, PO Box 210039, Cincinnati, Ohio 45221-0039
If you have questions, contact UC HR at (513) 556-6381.

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