Sedgwick County... working for you

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.sedgwickcounty457.com or contact Service Provider at 1-800-701-8255.

Sedgwick County, KS 457 Deferred Compensation Plan **98968-01**

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)*

Investment balances and future allocation elections will not change as a result of this correction.

C Signatures and Consent

Participant Consent

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)*

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	98968-01 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:
Great-West Retirement Services®
PO Box 173764
Denver, CO 80217-3764

OR

Express Mail to:
Great-West Retirement Services®
8515 E. Orchard Road
Greenwood Village, CO 80111

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