



Personal Information Change Request 401(k) 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, contact Service Provider at 1-800-922-7772.

State of Tennessee 457 and 401(k) Plans

98986

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 _____

Personal Phone Number _____ Work 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/Trustee Approval (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/Trustee Signature _____ Date (Required) _____

D Mailing Instructions

Participant forward to Employer
Employer forward to Service Provider

Great-West Retirement Services®
Regular Mail:
PO Box 173764
Denver, CO 80217-3764

Phone: 1-800-922-7772
Fax: 1-866-745-5766
Website: www.treasury.tn.gov/dc

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

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