



Beneficiary Address Change Defined Benefit Plan

For Active and Deferred Members

FOR OFFICE USE ONLY

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Select your system: ☐ PERS ☐ TRS ☐ JRS ☐ EPORS

SECTION I - PERSONAL DATA

Employee's Name (Last, First M.I.)	RIN or Last 4 of SSN	Page ____ of ____ (Use only if additional forms are attached)
Mailing Address (Street or P.O. Box, City, State, Zip)		Work Telephone Number
Marital Status	Date of Birth	Home Telephone Number
Employer Name		Employer Number

SECTION II - BENEFICIARY DATA

Last Name, First, M.I.	
Mailing Address (Street or P.O. Box, City, State, Zip)	Social Security Number

Last Name, First, M.I.	
Mailing Address (Street or P.O. Box, City, State, Zip)	Social Security Number

Last Name, First, M.I.	
Mailing Address (Street or P.O. Box, City, State, Zip)	Social Security Number

Last Name, First, M.I.	
Mailing Address (Street or P.O. Box, City, State, Zip)	Social Security Number

I understand that this changes the contact information for the above listed beneficiary(ies) only, and that all other beneficiary information from the previously submitted form (02-822) remains in effect.

I hereby certify that the information provided on this form is true and correct to the best of my knowledge. I understand that any deliberate misrepresentation for the purpose of obtaining benefits is an offense punishable by law.

Signature of Employee	Date
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