RETIREMENT PLAN ELECTION
Post-Doctoral Research Associates only

CO-931 PD-II

This form should be completed for all currently employed Post Doctoral research associates at the University of Connecticut (excluding UConn Health) who were hired on or after November 19, 2021. The form must be signed by the employing agency and the employee and returned to the Retirement Services Division as soon as possible following the Post Doctoral Research Associate's employment date or post-hire enrollment date resulting from a recent eligibility status determination.

CHECK TYPES OF ACTIONS BEING SUBMITTED ON THIS FORM

I. EMPLOYEE'S PERSONAL INFORMATION

LAST NAME	FIRST NAME	MI	EMPLOYEE NO	SOCIAL SECURITY NO.	DATE OF BIRTH	GENDER ☐MALE ☐FEMALE
ADDRESS (No., Street, City, State, Zip Code)						
MARITAL STATUS ☐ MARRIED ☐ SINGLE	DATE OF MARRIAGE	NAME OF SPOUSE				

II. EMPLOYMENT INFORMATION

EMPLOYING AGENCY	RECORD NO.	AGENCY ADDRESS		
UConn-Storrs		9 Walters Ave., Storrs, CT 06269		
EMPLOYMENT DATE	BARG. UNIT	CORE-CT JOB CODE	EMPLOYMENT STATUS	TYPE STATUS
	31	AA9001	☐ Full-time ☐ Part-time	Durational

III. RETIREMENT ELECTON INFORMATION

☐ Option 1 – Alternate Retirement Program – employee contribution 5%, prospective only

☐ Option 2— Waiver of retirement plan membership

IV. AGENCY SECTION

EMPLOYEE CODE	START DATE ___/___/___	
EMPLOYER CODE	START DATE ___/___/___	

V. PARTICIPANT'S STATEMENT

I understand that this is an irrevocable decision, and I cannot at a later date select another retirement plan participation option.

EMPLOYEE'S SIGNATURE	EMPLOYEE NUMBER	DATE
AUTHORIZED AGENCY SIGNATURE & TITLE (Benefit Specialist)	PHONE NO. 860-486-3034	DATE

DESIGNATION OF RETIREMENT PLAN BENEFICIARY FORM FOR ACTIVE/INACTIVE MEMBERS

CO-999 6/2018

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
RETIREMENT SERVICES DIVISION

I. EMPLOYEE PERSONAL INFORMATION

MEMBER STATUS: NEW MEMBER ☐ ACTIVE MEMBER ☐ INACTIVE MEMBER ☐

INACTIVE MEMBERS (ONLY):
NEW ADDRESS ☐ NAME CHANGE ☐

LAST NAME	FIRST NAME	M.I.	EMPLOYEE NO.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER MALE ☐ FEMALE ☐

ADDRESS (Street No., Name) (City, State, Zip Code)

MARITAL STATUS	DATE OF MARRIAGE	NAME OF SPOUSE
MARRIED ☐ SINGLE ☐		

II. BENEFICIARY DESIGNATION

- Type or PRINT clearly.
- You may name any living person, your estate, a trust, or a charitable organization as your beneficiary.
- At least one beneficiary must be named. If more than one primary beneficiary is named, the share of the beneficiary who dies before you shall be divided equally among the surviving beneficiaries.
- A payment is made to a contingent beneficiary(ies) only if all primary beneficiaries die before you do.
- If you survive all of the beneficiaries named, payment would be made to your estate.
- To designate a trust as beneficiary enter the name and date of the trust agreement in the Beneficiary section of this form; leave the Relationship and Social Security sections blank; and indicate Primary or Contingent.
- To designate your estate as beneficiary enter the word "Estate" in the beneficiary section of this form; leave the Relationship and Social Security sections blank; indicate Primary or Contingent.

Primary beneficiary(ies) must equal 100%. Contingent beneficiary(ies) must equal 100%. Please use whole percentages. If there are more than (4) beneficiaries designated, check the box to the right and attach an additional CO-999 form listing additional beneficiaries. ☐

NAME OF BENEFICIARY PRIMARY ☐			SOCIAL SECURITY NUMBER	NAME OF BENEFICIARY PRIMARY ☐ CONTINGENT ☐			SOCIAL SECURITY NUMBER
Last Name	First Name	M.I.		Last Name	First Name	M.I.	
ADDRESS (Street No., Name)			RELATIONSHIP	ADDRESS (Street No., Name)			RELATIONSHIP
(City, State, Zip Code)		PERCENT	DATE OF BIRTH	(City, State, Zip Code)		PERCENT	DATE OF BIRTH

NAME OF BENEFICIARY PRIMARY ☐ CONTINGENT ☐			SOCIAL SECURITY NUMBER	NAME OF BENEFICIARY PRIMARY ☐ CONTINGENT ☐			SOCIAL SECURITY NUMBER
Last Name	First Name	M.I.		Last Name	First Name	M.I.	
ADDRESS (Street No., Name)			RELATIONSHIP	ADDRESS (Street No., Name)			RELATIONSHIP
(City, State, Zip Code)		PERCENT	DATE OF BIRTH	(City, State, Zip Code)		PERCENT	DATE OF BIRTH

III. MEMBER'S STATEMENT

I hereby revoke all previous appointments of beneficiaries made by me, if any, and designate the person(s) named above as beneficiary(ies) such person(s) to receive upon my death any and all sums due me from the Retirement System of which I am a member. This designation shall remain in effect unless I subsequently change it by written notice to the Retirement Services Division.

EMPLOYEE'S SIGNATURE	DATE	
AUTHORIZED AGENCY SIGNATURE (& TITLE) (Benefit Specialist)	PHONE 860-486-3034	DATE

Forward completed form to: Retirement Services Division, Customer Service Center, 55 Elm Street, Hartford, CT 06106. Agency should retain one copy and provide one copy to employee.