

NEWTON COUNTY HUMAN RESOURCES

Employee Information Change Form

TYPE OF CHANGE:

Name Change Address Change Telephone Number Emergency Contact Change All

Effective Date: _____ Department : _____

FROM: (PLEASE PRINT CLEARLY)

Name _____

Address _____ City, State, Zip _____

Home Phone _____ Cell Phone _____

TO: (PLEASE PRINT CLEARLY)

Name _____

Address _____ City, State, Zip _____

Home Phone _____ Cell Phone _____ Email _____

MAILING ADDRESS: (If different from address)

Name _____

Address _____ City, State, Zip _____

EMERGENCY CONTACT: _____ (Relationship) _____

EMERGENCY CONTACT #'s () _____ () _____

PLEASE NOTE: Changes on this form will also be updated on your medical and dental insurance if applicable.
Address Changes for ICMA & CBIZ/GebCorp, must be made using their forms which are attached. Address changes to Colonial Life must be made directly through the vendor at 800-845-7330.

Signature

Today's Date



PARTICIPANT DATA CHANGE FORM

Please complete the section(s) that apply to your request
(Any incomplete forms will be returned)

Section I: Personal Information [] Active Participant [] Retiree [] Terminated Participant

Participant Name: _____ Employer/Jurisdiction Name: _____

Social Security #: _____ E-mail Address: _____ Phone Number: _____

Section II: Name Change (please submit a copy of the appropriate court documentation for your name change)

[] Name Changed From: _____

Section III: Address Change [] Password Letter Request

[] New Address: _____ [] Old Address: _____

Section IV: Beneficiary Information (Check all Plan boxes to which the changes apply)

[] 401(a) Defined Contribution Plan [] 457 Deferred Compensation Plan [] Defined Benefit Pension Plan

- You may use this form to designate the same beneficiary(ies) for all plans in which you participate. If you wish to designate different beneficiary(ies) for each plan in which you participate, you must complete a separate form for each plan
If you name more than one primary or contingent beneficiary, the "% to Beneficiary" for the category must equal 100%
The "% to Beneficiary" can be split up to two decimal points (Example: 33.33%)
The beneficiary(ies) designated on this form relates only to the receipt of Lump Sum or Balance of Period Certain Benefits payable under the Defined Benefit Pension Plan

I hereby designate the following beneficiary(ies) to receive any death benefits payable under the referenced retirement plan(s), still reserving the privilege of future changes with the exception of the contingent/survivor benefit for the DB Plan. As a participant, I do hereby revoke any previous beneficiary information, and specify the below named persons as my beneficiary(ies).

PRIMARY BENEFICIARY

If more space is needed, an additional sheet may be attached to this form

Form fields for the first beneficiary: NAME OF PRIMARY BENEFICIARY, [] Male, [] Female, SS#, DATE OF BIRTH, RELATIONSHIP, ADDRESS, % TO BENEFICIARY

PLEASE CHECK PRIMARY OR CONTINGENT FOR THE ADDITIONAL BENEFICIARY(IES)

PRIMARY [] CONTINGENT []

Form fields for the second beneficiary: NAME OF PRIMARY BENEFICIARY, [] Male, [] Female, SS#, DATE OF BIRTH, RELATIONSHIP, ADDRESS, % TO BENEFICIARY

PRIMARY [] CONTINGENT []

Form fields for the third beneficiary: NAME OF PRIMARY BENEFICIARY, [] Male, [] Female, SS#, DATE OF BIRTH, RELATIONSHIP, ADDRESS, % TO BENEFICIARY

If more than one primary beneficiary is designated, settlement will be made to each in equal shares unless otherwise specified above. If primary beneficiary(ies) does not survive me, settlement will be made to the contingent beneficiary(ies). If no designated beneficiary survives me, settlement will be made as designated by the Plan documents.

Participant Signature: _____ Date: _____

Witness Signature: _____ (Must not be listed as beneficiary)

Return To:

GEBCorp, 400 Galleria Parkway, Ste. 1250, Atlanta, GA 30339 or Fax to 770.563.9356 Phone 770.952.5225 or 800.736.7166



EMPLOYEE INFORMATION CHANGE FORM

Use this form to make **name, marital status, or beneficiary changes** in your existing ICMA Retirement Corporation 457 Deferred Compensation Plan, 401 Money Purchase Plan, or 401 Profit-Sharing Plan accounts.

For address changes, investment allocation changes or fund transfers, use VantageLink (www.icmarc.org) or VantageLine (1-800-669-7400).

If you wish to make a change to your payroll deduction, please use the *457 Deferred Compensation Plan Amount of Deferral Change Form* or the *401 Amount of Contribution Change Form*, depending upon your retirement plan type.

If this request requires your employer's approval, submit the completed form for signature before forwarding it to ICMA-RC. **(If you fax the form to ICMA-RC, please do not mail the original.)**

1 Personal Information (All information in this section must be completed.)	Employer Plan Number _____	Employer Plan Name _____	State _____	
	Social Security Number _____	ADDRESS: _____		
	Full Name of Participant _____			
	Last _____		First _____ M.I. _____	

2 Name Change <i>(Note: For name changes, you must attach a copy of a legal document (copy of driver's license, etc.) and have Employer approval.)</i>	Make this change ONLY to the following plan(s):			
	Employer Plan Number: _____	Employer Plan Name: _____	State: _____	
	Employer Plan Number: _____	Employer Plan Name: _____	State: _____	
	Full New Name of Participant _____			
Last _____		First _____ M.I. _____		

3 Primary Beneficiary Change <i>(Please read important beneficiary information on the back of this form before completing this section.)</i>	Complete this section ONLY if you want to change or add a primary beneficiary. Otherwise, if you do not complete this section, your primary beneficiary information will be according to your previous designation.				
	The changes you indicate here will apply only to the plan account you indicated in section #1 above. If you have other ICMA-RC accounts with other employers and you wish to make a primary beneficiary change to those accounts, please fill out one form for each employer account.				
	The primary beneficiary information you indicate here will supercede previously submitted information and will be used by ICMA-RC to determine the primary beneficiaries entitled to all or a portion of your plan account.				
	Name of Primary Beneficiary(ies)	Date of Birth	Relationship to you	Social Security Number	% of benefit *
_____	____/____/____	<input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	_____	_____	
_____	____/____/____	<input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	_____	_____	

*Must total 100%. Use whole percentages only.

4 Contingent Beneficiary Change <i>(Please read important beneficiary information on the back of this form before completing this section.)</i>	Complete this section ONLY if you want to change or add a contingent beneficiary. Otherwise, if you do not complete this section, your contingent beneficiary information will be according to your previous designation.				
	The changes you indicate here will apply only to the plan account you indicated in section #1 above. If you have other ICMA-RC accounts with other employers and you wish to make a contingent beneficiary change to those accounts, please fill out one form for each employer account.				
	The contingent beneficiary information you indicate here will supercede previously submitted information and will be used by ICMA-RC to determine the contingent beneficiaries entitled to all or a portion of your plan account.				
	Name of Primary Beneficiary(ies)	Date of Birth	Relationship to you	Social Security Number	% of benefit *
_____	____/____/____	<input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	_____	_____	
_____	____/____/____	<input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	_____	_____	

*Must total 100%. Use whole percentages only.

5 Marital Status Change - Please check one box.	Make this change ONLY to the following plan(s):			
	Employer Plan Number: _____	Employer Plan Name: _____	State: _____	
	Employer Plan Number: _____	Employer Plan Name: _____	State: _____	
	New Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single			

6 Authorizations	Participant Signature _____	Date _____	Employer Signature (if required) _____	Date _____
	Spousal Signature _____	Date _____	All 401 plans with marital rights require the spouse as 100% primary beneficiary, unless your spouse waives this right by signing here.	