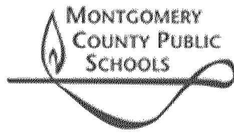

Personal Information Change Request
Governmental 457(b) Plan

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, contact Service Provider at 1-800-543-2520.

1013899-01 MONTGOMERY COUNTY PS (PS DCP)

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.

Social Security Number ______ Account Extension ______

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 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

MetLife c/o FASCore, LLC
Regular Mail:
PO Box 173768
Denver, CO 80217-3768

Phone: 1-800-543-2520
Fax: 1-866-745-5766
Website: www.mlr.metlife.com

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

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