Address Change

Form W-4 (2015)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . A ______

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

. . . B ______

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . C ______

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . D ______

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . E ______

F Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . F ______

(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.

- If your total income will be less than $65,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children.
- If your total income will be between $65,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child . . . G ______

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ► H ______

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

OMB No. 1545-0074 **2015**

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

1 Your first name and middle initial	Last name	2 **Your social security number**

Home address (number and street or rural route)

3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.

Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

City or town, state, and ZIP code

4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) | 5 |

6 Additional amount, if any, you want withheld from each paycheck . . . . . | 6 | $

7 I claim exemption from withholding for 2015, and I certify that I meet **both** of the following conditions for exemption.

- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . . ► | 7 |

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ► **Date ►**

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2015 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1951) of your income, and miscellaneous deductions. For 2015, you may have to reduce your itemized deductions if your income is over $309,900 and you are married filing jointly or are a qualifying widow(er); $284,050 if you are head of household; $258,250 if you are single and not head of household or a qualifying widow(er); or $154,950 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,250 if head of household; $6,300 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2015 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2015 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2015 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,000 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4			
5	Enter the number from line 1 of this worksheet	5			
6	**Subtract** line 5 from line 4			6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here			7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . .			8	$
9	Divide line 8 by the number of pay periods remaining in 2015. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2015. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck			9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $8,000	0
6,001 - 13,000	1	8,001 - 17,000	1
13,001 - 24,000	2	17,001 - 26,000	2
24,001 - 26,000	3	26,001 - 34,000	3
26,001 - 34,000	4	34,001 - 44,000	4
34,001 - 44,000	5	44,001 - 75,000	5
44,001 - 50,000	6	75,001 - 85,000	6
50,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$600	$0 - $38,000	$600
75,001 - 135,000	1,000	38,001 - 83,000	1,000
135,001 - 205,000	1,120	83,001 - 180,000	1,120
205,001 - 360,000	1,320	180,001 - 395,000	1,320
360,001 - 405,000	1,400	395,001 and over	1,580
405,001 and over	1,580		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

DELTA DENTAL

ENROLLMENT/CHANGE FORM

Delta Dental of Arkansas
P.O. Box 15965
North Little Rock, AR 72231
E-mail: eligibility@ddpar.com
Fax (501) 992-1890

☐ New Enrollment ☐ Status Change ☐ Address Change ☐ Termination

☐ Dental Only ☐ Vision Only ☐ Dental/Vision ☐ Cobra

Effective Date

Month	Day	Year

Group Number: ____________________

Group Name: ____________________

Social Security Number

Subscriber's Identifier (if applicable)

LAST NAME: ____________________ FIRST: ____________________ MI: ____

STREET ADDRESS: ____________________

CITY: ____________________ STATE: __________ ZIP: __________

EMAIL: ____________________

Date of Birth ___ / ___ / ___ (MM DD YY)

Marital Status ☐ Single ☐ Married

Sex ☐ Male ☐ Female

Date of Hire ___ / ___ / ___ (MM DD YY)

NOTE: Certain medical conditions may entitle you and/or you covered dependents to additional benefits. Please mark any conditions that apply to you (Under section 2 below, please ent Code for affected dependents in the box entitled "EBD Code." Enter P for pregnant, D for diabetes, and H for Heart Disease)

☐ Pregnancy - Expected due date ____________________
☐ Diabetes - Date of onset ____________________
☐ Heart Disease - Date of onset ____________________

1. COVERAGE CHANGES

* Please check the box(es) next to the reason(s) for your change

Type coverage selected (choose one)

Dental
☐ Employee
☐ Employee/Spouse
☐ Employee/Child
☐ Employee/Children
☐ Employee/Family

Vision
☐ Employee
☐ Employee/Spouse
☐ Employee/Child
☐ Employee/Children
☐ Employee/Family

☐ Add Dependent(s) listed below
☐ Remove Dependent(s) listed below
☐ Name Change
☐ Late Entrance (employee)

☐ Change Coverage
☐ Address Change only
☐ Qualifying event
☐ Late Entrance (dependent)

Reason(s) for Change:
☐ Marriage
☐ Divorce
☐ Birth or adoption of child
☐ Full Time Student
☐ Handicapped
☐ Other ____________________
☐ COBRA effective date ____________________

Date of event ____________________
☐ Loss of spouse's coverage
☐ No longer dependent child
☐ Death of dependent
☐ No longer Full Time Student
____

2. LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Dental	Vision	Add	Remove	EBD Code	Onset Date	Last (if different)	First	MI	Relationship	Sex M/F	Birthdate (MM/DD/YY)
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								

3. AUTHORIZATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (includin without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authori tion is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. The authorization is valid for the term of coverage for th purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

4. CERTIFICATION

I certify that the information supplied by me on this form is accurate to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

☐ I have been offered the opportunity to enroll in the dental and/or vision program through Delta Dental; however, **I waive coverage at this time.**
☐ I authorize payroll deductions.

Signature: ____________________ Date: ____________________

DV-ENR-11-

☐ UnitedHealthcare Insurance Company of the River Valley (PPO)

APPLICATION/CHANGE FORM

PERSONAL AND CONFIDENTIAL

Employer	Group No. & Billing Loc.	HMO ☐ Select ☐ Choice ☐ Choice Standard ☐ Select Advantage *(Iowa only)* ☐ Premier	PPO ☐ ______	Effective Date

REQUESTED ACTION Sign and date in Section F.

☐ **ENROLLMENT APPLICATION** ☐ **COBRA APPLICATION** ☐ **CONVERSION APPLICATION** ☐ **CONTINUATION APPLICATION**

☐ **CHANGE NOTICE:** (Check desired changes) ☐ Add ☐ Remove Dependent(s) **(List dependent(s) to add or remove in Section B.)**

Qualifying Event ______ **Effective Date** ______

☐ Change Coverage to: ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

☐ Cancel Coverage Effective:______ ☐ Change Name From:______ (List New Name in Section A or B.)

☐ Change of Address - (List new address in Section A.) ☐ Other (Specify:)______

☐ Change Coverage to Surviving Spouse:

Name of Original Policyholder______ Subscriber Number______ Date of Death______

A. SUBSCRIBER DATA

Social Security Number	Name (Last, First, MI)	Date of Birth (Month, Day, Year)	M/F

Address (Include Street, R.R., Apt. No.)	City	State	Zip	County	Area Code and Phone Number

Primary Care Physician (PCP)	Coverage ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family
Employment Status ☐ Active ☐ Retired ☐ Surviving Spouse	**Full-Time Hire Date**

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐ Common Law Notarized Affidavit *(Applies to Iowa only)*

B. SPOUSE/DEPENDENT DATA: NEW APPLICATIONS - List persons to be covered. **CHANGES** - List persons to be added or removed.

Name (Last, First, MI)	Birth date (Month, Day, Year)	M/F	Relationship	Social Security Number	Primary Care Physician (PCP) Last Name, First Name
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

C. COORDINATION OF BENEFITS (Complete if any persons listed in Section B are covered by another insurance policy.)

Is your Spouse: ☐ Employed ☐ Retired Date of Marriage / /

Are any persons in Section A or B covered by another insurance policy? ☐ Yes ☐ No	If yes, list first names of all persons covered	If yes, give name of insurance company/HMO Member ID Number

D. MEDICARE DATA (Complete if any person(s) listed in Section A or B are covered by Medicare)

Name (Last, First, MI)	Medicare ID Number	Reason for Medicare (check one)			
		☐ Aged	☐ Disabled	☐ ESRD	☐ Hospice
		☐ Aged	☐ Disabled	☐ ESRD	☐ Hospice

E. PRIOR COVERAGE INFORMATION

Did you have health coverage within 63 days prior to the date on which you signed this application? ☐ Yes ☐ No If yes, please complete the remainder of this section.

If Full-Time Hire Date stated in Section A is within the past six months, did you have health coverage within 63 days prior to that date?

☐ Yes ☐ No ☐ N/A If yes, complete the remainder of this section.

Name of Covered Person(s)	Employer (if applicable)	Insurance Company/HMO Name and Address

Policy No.	Contract Type ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family	Effective Date	End Date

F. REPRESENTATION (Please review the above application for completeness and read the following statement before signing below.)

I represent to the best of my knowledge and belief that all statements and answers made in this application are complete and true, and I understand that the answers to the above questions will be the basis of any coverage issued. UnitedHealthcare Plan of the River Valley, Inc. and UnitedHealthcare Insurance Company of the River Valley may obtain information relating to the occupation, mode of living, and avocations in order to evaluate this application.

I have read this authorization and I agree that, the length of time of this authorization will be (1) for the purpose of collecting information in connection with an application, 30 months (Iowa only- 24 months) or less from the date of signing; and, (2) for the purpose of collecting information in connection with a claim for benefits, the term of coverage. I understand that, upon request, I am, or my authorized representative or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

I agree to abide by the provisions and regulations as set forth by the master contract applicable to the plan for which I have enrolled. Any material misrepresentation may result in re-rating of group premium, claim denial, and/or recision of coverage. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company/HMO for the purpose of obtaining health coverage or health insurance. Penalties may include imprisonment, fines, and denial of benefits.

Employee/Subscriber Signature ______ Date ______ Employer Signature ______ Date ______

APERS
ARKANSAS PUBLIC EMPLOYEES RETIREMENT SYSTEM

Requesting an Enrollment Change

Summary

This notice is provided on behalf of the Arkansas Public Employees' Retirement System (APERS) to members who need to change information in their enrollment record. This notice explains how to submit a valid enrollment change request.

Enrollment Change Provisions

When your personal data, contact information, or beneficiary designation changes; you should request that we change your enrollment information in our records.

Contact Information

- **Mailing Address** – You can change your address to any valid postal address. You should provide a complete address. A complete address contains all necessary address elements: House number (including apartment, suite or room numbers), Street Name, Directional (ex: N, E, S or W), City, State, and Zip Code.
- **Email Address** – You can change your email address to any valid email address. A valid email address contains three parts: the local-part (usually your email account username), the "@" sign, and the domain name (ex: employee@arkansas.gov).
- **Daytime Telephone** – You can change your telephone number to any number at which you can be contacted during our normal business hours of 7:30 am-4:30 pm. Provide the full 10-digit number including the area code.

Personal Data

- **Name** – You can change your name due to a legal name change. You must provide documentation to support the name change. Acceptable documentation includes a copy of any of the following documents: Marriage License, Divorce Decree, Court Order, or Social Security Card.
- **Marital Status** – You can change your marital status due to one of the following marital events recognized by the System: a marriage, divorce, or death of a spouse.
- **Spouse Information** – You can change your spouse information by adding or removing a spouse. You can add only a legally-recognized spouse.

Beneficiary Designation

You can change your employee contributions beneficiary at any time. The change will revoke all beneficiaries that you previously designated.

A beneficiary can be any of the following:

- An individual who is a citizen or resident of the United States except that you cannot be the individual,
- A partnership, corporation, company or association created or organized in or under the laws of the United States, or
- An estate (other than a foreign estate) or trust.

Request Form Instructions

To request an enrollment change, you must complete the *Enrollment Change Request* form and submit it to our office. The form must be completed by you and in some cases by a notary public.

The following information explains how to complete sections I through VI of the *Enrollment Change Request* form.

I. Member Information
You must provide your SSN, the name and address that is currently in our records, the 5-digit employer number, and employer name.

II. Contact Information Change
You must provide your new mailing address, email address and daytime telephone number.

III. Personal Data Change
You must provide your new name, marital status, and spouse information (name, date of birth, and gender).

IV. Beneficiary Designation Change
You must provide the SSN, name, date of birth, relationship and gender of your new beneficiary.

V. Member Certification
You must provide your signature and date to acknowledge that you received this publication and to authorize us to make the requested enrollment changes. Your signature also declares that your requested changes are not for deceptive reasons.

VI. Notary Acknowledgement
If you change your beneficiary, a notary public must complete this section to acknowledge your identity. Notaries must provide their signature and affix their seal or stamp. Your beneficiary designation will not be valid if this section is incomplete.

Additional Information

If you have any questions about requesting an enrollment change, please contact a call center representative toll free at 800-682-7377.

APERS
ARKANSAS PUBLIC EMPLOYEES RETIREMENT SYSTEM

Enrollment Change Request

124 West Capitol Avenue Suite 400 • Little Rock AR 72201-3700
Phone: (800)682-7377 • Fax: (501)682-7843 • Website: www.apers.org

I. Member Information

Social Security Number	Member Name(Last, First, Middle Initial)

Mailing Address	City, State, Zip Code

APERS Employer Number	APERS Employer Name

II. Contact Information Change

Mailing Address	City, State, Zip Code

Email Address	Daytime Telephone Number

III. Personal Data Change

Member Last Name	Member First Name	Member Middle Initial

Marital Status	Spouse Name (Last, First, Middle Initial or "None")
☐ Married ☐ Divorced ☐ Widowed	

Spouse Date of Birth (mm/dd/yyyy)	Spouse Gender
	☐ Female ☐ Male

IV. Beneficiary Designation Change

Social Security Number	Name (Last, First, Middle Initial)	
Date of Birth (mm/dd/yyyy)	Relation	Gender ☐ Female ☐ Male

Social Security Number	Name (Last, First, Middle Initial)	
Date of Birth (mm/dd/yyyy)	Relation	Gender ☐ Female ☐ Male

Social Security Number	Name (Last, First, Middle Initial)	
Date of Birth (mm/dd/yyyy)	Relation	Gender ☐ Female ☐ Male

Enrollment Change Request

Mail: 124 West Capitol Avenue Suite 400 • Little Rock AR 72201-3700
Phone: (800)682-7377 • Fax: (501)682-7843 • Website: www.apers.org

Social Security Number	Name (Last, First, Middle Initial)

V. Member Certification

- I acknowledge that I read the *Requesting an Enrollment Change* publication which explains the provisions for changing my enrollment information.
- I request and authorize APERS to make the personal data, contact information or beneficiary designation changes indicated above in sections II through IV. I declare that these changes are not for deceptive reasons.
- Beneficiary Changes: I revoke all beneficiaries who I previously designated and designate the person (or persons) above as beneficiary (or beneficiaries). I request the APERS Board of Trustees (Board) to pay the total amount of the accumulated contributions standing to my credit in the System to this person if my death occurs and there is no death benefit payable. I agree on behalf of myself, heirs and assigns that payment so made be a complete discharge of the claims and constitute a release of the System from any further obligations on account of the benefit.
- Beneficiary Changes: I hereby direct that should I survive the beneficiary, the amount which otherwise would have been payable to the beneficiary be paid according to the provisions of the retirement act or to such other beneficiary as I hereafter nominate by written designation filed with the System in accordance with the rules and regulations prescribed by the Board.

Member Signature	Date

VI. Notary Public Acknowledgement (Required only for [illegible] Changes)

State	County	Date Appeared	Affix seal or stamp here

Certificate of Acknowledgement

Before me, the undersigned notary, personally appeared the above-named employee satisfactorily proven to be the person whose name is subscribed to the within instrument and acknowledged that he or she executed the same for the purposes therein contained.

Notary Public Signature	Date Commission Expires