



CT TEACHERS' RETIREMENT BOARD
 765 ASYLUM AVENUE HARTFORD, CT 06105-2822
 Toll-Free 1-800-504-1102 (860) 241-8400 Fax (860) 525-6018 www.ct.gov/trb

CHANGE OF BENEFICIARY RETIREMENT PLAN N (NORMAL ALLOWANCE)

This form supersedes and replaces any previous beneficiary designations. All items pertaining to beneficiaries must be completed in order for the Connecticut Teachers' Retirement Board (CTRB) to process the form; incomplete forms will be returned.

- Include a complete list of all beneficiaries.
- Type or print clearly in ink and do not use white out.
- Do not submit an amended copy of a previous beneficiary form.
- You may name any living person, your estate, a trust, or a charitable organization as your beneficiary.
- At least one primary beneficiary must be named. If more than one primary beneficiary is named, the share of any beneficiary who dies before you shall be divided equally among the surviving primary 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 issued to your estate.
- "Per Stirpes" designations (unnamed or unborn beneficiaries) are not accepted.
- All information must appear in the appropriate section of this form.
- To designate a trust as a beneficiary enter the name and date of the trust agreement in the Beneficiary section of this form; leave the Relationship and Social Security sections of this form blank; and indicate Primary or Contingent.
- To designate your estate as a beneficiary enter the word "Estate" in the Beneficiary section of this form; leave the Relationship and Social Security sections of the form blank; and indicate Primary or Contingent.

RETIRED MEMBER INFORMATION:

MEMBER NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)	SOCIAL SECURITY #	PHONE NUMBER
STREET ADDRESS	EMAIL	
CITY, STATE, ZIP	CHECK IF: NEW ADDRESS <input type="checkbox"/> NAME CHANGE <input type="checkbox"/>	

I hereby revoke any previously recognized beneficiary designation and elect to name the following individual(s) as my designated beneficiary(ies). I understand that under the terms and conditions of Payment Plan N, if I expire before I have received four times the amount in my account (contributions and interest), my designated beneficiary (or estate) will receive a lump sum payment of my account balance minus 25% of the benefits I received.

BENEFICIARY NAME AND ADDRESS (include ZIP Code)	RELATIONSHIP	SOCIAL SECURITY #	CHECK ONE
Name: Address:			<input type="checkbox"/> primary <input type="checkbox"/> contingent
Name: Address:			<input type="checkbox"/> primary <input type="checkbox"/> contingent
Name: Address:			<input type="checkbox"/> primary <input type="checkbox"/> contingent
Name: Address:			<input type="checkbox"/> primary <input type="checkbox"/> contingent
SIGNATURE OF MEMBER		DATE	

CTRB does not acknowledge the receipt of individual forms. Please retain a copy of this form for your records and forward it by fax or regular mail directly to CTRB at the address above.