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, visit the Web site at www.louisianadcp.com or contact Service Provider at 1-800-701-8255.

Louisiana Public Employees Deferred Comp. Plan **98228-01**

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.

Account Extension

Social Security Number *(Must provide all 9 digits)*

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, military ID, passport or court order)*

Last Name First Name M.I.

Address and/or Contact Information Change

Street Address City/State/Zip Code

( ) ( )

Daytime Phone Number Alternate 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 Signature *(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 Signature _____ **Date *(Required)*** _____

Last Name	First Name	M.I.	Social Security Number	98228-01 Number

D Mailing Instructions

After all signatures have been obtained, this form can be sent by

Fax to:
1-866-745-5766

OR

Regular Mail to:
State of Louisiana
PO Box 173764
Denver, CO 80217-3764

OR

Express Mail to:
State of Louisiana
8515 E. Orchard Road
Greenwood Village, CO 80111

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