

## 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 1-800-701-8255.

<b>350207-01 Texas City ISD Tax Deferred Savings Plan</b>			
<b>A</b>	<b>Participant Information (Provide Name, Social Security Number and Date of Birth as it currently appears on the account)</b>		
	Social Security Number	Account Extension	Account extension identifies funds transferred to a beneficiary due to death, alternate payee due to divorce or a participant with multiple accounts.
	Last Name	First Name	M.I.      Date of Birth / /
	I have a retirement savings plan with a previous employer or an IRA. <input type="checkbox"/> Yes or <input type="checkbox"/> No		
<b>B</b>	<b>Name Change (Attach a copy of birth certificate, divorce decree, marriage certificate or court order)</b>		
	Last Name	First Name	M.I.
	<b>Address and/or Contact Information Change</b>		
	Street Address	City ( ) ( )	State      Zip Code
	Personal Phone Number	Work Phone Number	Email Address
<b>C</b>	<b>Personal Information Change</b>		
	Date of Birth / /	(Attach a copy of Birth Certificate)	
	Change of Status		
	<input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Female <input type="checkbox"/> Male		
<b>D</b>	<b>Social Security Number Change (If I am still employed, I must obtain approval from my Employer)</b>		
	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.		
	<b>Signatures and Consent</b>		
<b>Participant Consent</b>			
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)	
<b>Authorized Plan Administrator/Trustee Approval (Required for Social Security Number changes only)</b>			
I certify and accept that the information provided by the participant on this form is correct.			
Authorized Plan Administrator/Trustee Signature		Date (Required)	
<b>Mailing Instructions</b>			
Participant forward to Employer			
Employer forward to Service Provider			
Great-West Retirement Services®			
Regular Mail:	Phone: 1-800-701-8255	Express Mail:	
PO Box 173764	Fax: 1-866-745-5766	8515 E. Orchard Road	
Denver, CO 80217-3764	Website: www.gwrs.com	Greenwood Village, CO 80111	

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