Change of Address Kit
for
Full Time Employees

Please complete the attached forms and return them to Human Resources - Records at Central. We will distribute the forms to the necessary offices.

☐ Authorization to Change Human Resources Data Form
   TCC Human Resources Phone Number 918-595-7945

☐ OK State and Education Employees Group Insurance Board Change of Address Form
   TCC Human Resources Phone Number 918-595-7855

☐ Teachers’ Retirement System of Oklahoma Personal Data Form
   Please note: It is not necessary to complete page two of this form if you are only changing your address.
   TCC Human Resources Phone Number 918-595-7990

☐ Annuity Carriers
   You must personally contact your annuity carrier to change information.
   TCC Human Resources Phone Number 918-595-7990
TULSA COMMUNITY COLLEGE

AUTHORIZATION TO CHANGE HUMAN RESOURCES DATA

PLEASE PRINT
NAME ____________________________________ EFFECTIVE DATE OF CHANGE _______________________
JOB TITLE _______________________________ SSN __________ __________________ __________________
CAMPUS _______________________________ WORK AREA ________________________________

CHANGE OF ADDRESS
New Address ______________________________

CHANGE OF PHONE NUMBER
New Number ______________________________

CHANGE OF MARITAL STATUS (Attach a copy of Marriage License, Divorce Decree, or other legal
document verifying name change. Also, attach a revised copy of Social Security Card).
**NOTE: All appropriate documents must be attached before requested change can be made.

New Marital Status
☐ Married
☐ Single

Change of Name
Former Name ______________________________
New Name ______________________________

CHANGE OF HIGHEST DEGREE (Attach original transcript)
☐ Associate ☐ Bachelor ☐ Masters ☐ Doctorate
Degree Source ______________________________

CHANGE OF DISABILITY STATUS
☐ Not Disabled ☐ Hearing ☐ Mental or Psychological
☐ Mobility ☐ Speech ☐ Other ______________________________
☐ Sight ☐ Learning

CHANGE OF CITIZENSHIP STATUS
☐ US Citizen ☐ Alien Authorized to Work in the US
☐ Lawful Permanent Resident
Expiration Date ______________________________

CHANGE OF EMERGENCY CONTACT

Name ______________________________ Relationship ______________________________
Address ______________________________ City __________ State _______ Zip ________
Phone ______________________________ Business Phone ______________________________

Employee Signature ______________________________ Date __________________

**NOTE: THIS DOCUMENT AUTHORIZES TULSA COMMUNITY COLLEGE HUMAN
RESOURCES DEPARTMENT TO MAKE CHANGES TO YOUR HR FILE ONLY. Separate notification
is necessary to make these changes for Benefits, Teacher’s Retirement, and annuities. Please contact the
appropriate Human Resources staff member.

This document will become a part of your HR file. HR __________ Date __________ Rev. 6/02
OKLAHOMA STATE AND EDUCATION EMPLOYEES
GROUP INSURANCE BOARD
3545 NW 58th, Suite 110
Oklahoma City, Oklahoma 73112
1-405-717-8701 or toll-free 1-800-543-6044
TDD: 1-405-949-2281 or toll-free 1-866-447-0436
FAX: 405-717-8939

CHANGE OF ADDRESS

Member Name _______________________________________________________

SSN or Member ID # ________________________________________________

Member Phone Number ______________________________________________

New Address _______________________________________________________

Change in Marital Status: Married ___ Single ___ Divorced ___
Effective date of change: ___________________________________________

Member's Signature _______________________________________________

Date _____________________________________________________________

Current Employees – Return this form to your Insurance Coordinator.

Former Employees – Return this form to OSEEGIB at the address or FAX number listed above.

Revised 09/03/2010
OKLAHOMA TEACHERS' RETIREMENT SYSTEM
P.O BOX 53524 - OKLAHOMA CITY, OK 73152

BENEFICIARIES DESIGNATION

☐ Active  ☐ Retired

Name ___________________________________________ SSN# or Rot# __________________________

Address ___________________________________________ City __________________________ State ____________ Zip ______

All information (full name, date of birth, age, relationship and address of proposed beneficiary/beneficiaries) must be completed.

SECTION 1 - PRIMARY BENEFICIARY(IES): is the sole beneficiary if living at the member's death. If more than one beneficiary is named in this section, the interest of all beneficiaries shall be equal. Upon the death of any designated primary beneficiary, his/her interest shall pass to the surviving primary beneficiaries in equal share. If you have more than 2 beneficiaries, use a copy of this page.

1. I hereby designate

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Date of Birth</th>
<th>Age</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Address</th>
</tr>
</thead>
</table>

2. I hereby designate

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Date of Birth</th>
<th>Age</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Address</th>
</tr>
</thead>
</table>

as my primary beneficiary(ies) if living, or in the event of prior death of all primary beneficiaries, then payment is to be made to the contingent beneficiaries in Section 2.

SECTION 2 - CONTINGENT BENEFICIARY(IES): does not share in the amount due if any of the primary beneficiaries are living at the member's death. Payment will be made to the contingent beneficiaries if all primary beneficiaries are deceased. If more than one contingent beneficiary is named, payment will be made in equal shares. Upon the death of a contingent beneficiary, his/her interest shall pass to the surviving contingent beneficiaries in equal shares. If you have more than 2 contingent beneficiaries, use a copy of this page.

1. I hereby designate

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Date of Birth</th>
<th>Age</th>
</tr>
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<table>
<thead>
<tr>
<th>Relationship</th>
<th>Address</th>
</tr>
</thead>
</table>

as my contingent beneficiary(ies) to receive the amount set forth in the Teachers' Retirement Law in the event of my death. (Contingent beneficiaries do not share in the amount due if any of the primary beneficiaries are living at my death.)

Minor Beneficiary: Under Oklahoma law, if a minor child (younger than 18 years of age) is designated as beneficiary, it will be necessary that a guardian be appointed by the court before payment is made.

Revoking Previous Designation of Beneficiary: By this election, I hereby revoke all other former designations made by me and expressly reserve the right to make other and further changes at any time I may elect. If there is no designated beneficiary living at the time of my death, any amount due me shall be paid as provided by the Teachers' Retirement Law.

__________________________  __________________________
Signature                        Date

(The signature must appear exactly as the name appears on the top of this form. Power of attorney or Guardian signature not valid unless accompanied by court order specifically authorizing the right to change beneficiaries.)

(Rev. 03/10)
Annuity Changes

To change your 403(b) account address contact Greg Ruley at (918) 582-8206 or make changes online at INGretirementplan.com. If you have any additional questions please contact me at extension 7990.

Thank You,

Christa Harris
Compensation Analyst
CHANGE ADDRESS FORM

INSURED/POLICYHOLDER INFORMATION:

Address Change is for:

☐ Insured/policyholder (Print name) ___________________________ SSN ____________

☐ Policyowner (Print name) ___________________________ SSN ____________

Person Requesting the Change:

☐ Insured/policyholder ☐ Policyowner ☐ Other (Print name) ___________________________

If Other, please list relationship to insured/policyholder or policyowner: ___________________________

I understand this request for change of address will replace all previous requests. It will become effective the earlier of the request change date above or the date recorded by the home office below.

Signature of Requestor ___________________________ Date ___________________________

OLD ADDRESS:

Mailing ___________________________
Address: ___________________________

P.O. Box: ___________________________
City: ___________________________
State: ___________ Zip Code: ___________ Telephone Number (____) ___________________________

NEW ADDRESS:

Mailing ___________________________
Address: ___________________________

P.O. Box: ___________________________
City: ___________________________
State: ___________ Zip Code: ___________ Telephone Number (____) ___________________________

FOR HOME OFFICE USE ONLY

The foregoing request has been recorded at the Home Office of American Fidelity Assurance Company in Oklahoma City, Oklahoma.

Date: ___________________________ Approved By: ___________________________

PS-144- AFES