ERS
EMPLOYEES RETIREMENT SYSTEM OF TEXAS

PRIOR 457 DEFERRED COMPENSATION PLAN - CHANGE AGREEMENT

STATE EMPLOYEE:
- This form is used for stopping deferrals, changing product investment or beneficiary
- Return this form to your agency's Deferred Compensation Coordinator and send copy to ERS.
- All blanks must have an entry. Enter "N/A" if blank is not applicable.

PLEASE TYPE OR PRINT

Information provided to Employees Retirement System of Texas (ERS) is maintained for administration of your benefits. If you have questions about your information, or believe that information provided to ERS may be incorrect, please notify ERS.

Type of Change:	☐ Beneficiary	☐ Stop deferrals
Complete Items:	1, 2, 4, 5, 6, 7	1, 2, 3, 5, 6,7 (for life products only)

1. EMPLOYEE INFORMATION

Employee Name: Last, First, MI	Date of Birth	Social Security Number	Daytime Phone Number

Mailing Address	City	State	ZIP Code

2. VENDOR AND PRODUCT INFORMATION:

Vendor name	DCP number

Type of product (A separate form must be completed for each product.)

☐ Fixed annuity ☐ Group fixed annuity ☐ Group variable annuity ☐ Variable annuity ☐ Term life insurance ☐ Whole life insurance

3. CURRENT VENDOR STOP DEFERRALS:

Vendor name	Product	DCP number

☐ Stop deferrals to current vendor effective with earnings for the month/year _____/_____ $ _____

4. BENEFICIARY INFORMATION: (Required for all actions) *Only Beneficiary Designations made on ERS Prior 457 plan forms will be honored.*

Primary Beneficiary: Last, First, MI	Relationship	Social Security Number	Date of birth
Mailing Address	**City**	**State**	**ZIP Code**
Secondary Beneficiary: Last, First, MI	**Relationship**	**Social Security Number**	**Date of birth**
Mailing Address	**City**	**State**	**ZIP Code**

5. EMPLOYEE AUTHORIZATION AND ACKNOWLEDGMENT:

I understand that I am responsible for monitoring the financial stability of the vendors I invest with and the market conditions of their investments. Participant withdrawal of funds from the Plan may be made only under the following circumstances: unforeseeable emergency, death, de minimis (one-time) election, age 70½, or termination of State employment.

I acknowledge that I have read the Employees Retirement System of Texas Summary of Benefit Programs booklet, and I understand the terms, conditions and provisions of the plan.

_____ _____

Employee sign here Date

6. STATE OF TEXAS ATTEST:

Agency name	Agency number	Phone number
Authorized Agency Representative	**Title**	**Date**

7. ERS AUTHORIZATION:

_____ _____

Sign here Date