



ACTIVE MEMBER DATA CHANGE

State Form 43567 (R7 /3-08)

Approved by State Board of Accounts, 2008

Indiana State Teachers' Retirement Fund
150 West Market St., Suite 300
Indianapolis, IN 46204-2809
Telephone: (317) 232-3860 / (888) 286-3544
Website: www.in.gov/trf

PRIVACY NOTICE

Your TRF number is required on this form. Without it our agency cannot process your request. To obtain your number, feel free to call our office at (317) 232-3860 or toll free at (888) 286-3544.

PLEASE USE BLACK INK ONLY

MEMBER IDENTIFICATION

Full name of member		TRF number (required)	Date of birth	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single
Home telephone number () -	Work telephone number () -	Email address		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

CHANGE OF ADDRESS

Old address (number and street)			New address (number and street)		
City	State	Zip code	City	State	Zip code

CHANGE OF BENEFICIARY

Primary beneficiary(s) – receive any remaining benefits in equal shares. Contingent beneficiary(s) – receive equal shares if the primary beneficiary predeceases the member. For each beneficiary named, please indicate primary or contingent in the appropriate box. **Note:** All previous designees will be deleted and replaced with your new selections. Your account will be edited to match what is listed below. For additional beneficiaries, please attach a sheet to this form and follow the same format as below.

Full name of beneficiary #1	Social security number	Date of birth	Relationship	<input type="checkbox"/> Primary beneficiary <input type="checkbox"/> Contingent beneficiary
Full name of beneficiary #2	Social security number	Date of birth	Relationship	<input type="checkbox"/> Primary beneficiary <input type="checkbox"/> Contingent beneficiary
Full name of beneficiary #3	Social security number	Date of birth	Relationship	<input type="checkbox"/> Primary beneficiary <input type="checkbox"/> Contingent beneficiary
Full name of beneficiary #4	Social security number	Date of birth	Relationship	<input type="checkbox"/> Primary beneficiary <input type="checkbox"/> Contingent beneficiary

MEMBER ATTESTS THAT ALL CHANGES ARE TRUE TO THE BEST OF HIS / HER KNOWLEDGE

Member signature (required)	Date
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NAME CHANGE AFFIDAVIT

Previous name (please print or type)	New name (please print or type)
I, the undersigned, hereby affirm that there is no fraudulent intent in the decision to change my name. It is my wish that from this day forward, my retirement account at the Indiana State Teachers' Retirement Fund be maintained under the new name as listed above:	
Member signature	Date
In lieu of this affidavit, one of the following documents may be submitted: <ul style="list-style-type: none"> ▪ A copy of your marriage certificate ▪ A copy of your divorce decree restoring your former name; or ▪ A copy of the court order whereby you have legally changed your name. 	

NOTARY PUBLIC CERTIFICATION (For name change only)

State of _____ SS: _____
County of _____

Before me the undersigned, A Notary Public for _____ County,
Officer's county of residence

State of _____, personally appeared _____
Name of person

And they, being first duly sworn by me upon their oath, say that the facts alleged in the foregoing instrument are true.

Signed and sealed this _____ day of _____, 200__.

(Signature) _____
_____ Printed or typed name of officer

My commission expires: _____ (SEAL)