COLORADO PERA

PERA Benefit Structure Retirement Application

Colorado Public Employees' Retirement Association
PO Box 5800, Denver, Colorado 80217-5800
1-800-759-PERA (7372) • Fax: 303-863-3727 • www.copera.org

Your SSN ☐☐☐ ☐☐ ☐☐☐☐

Please read the *Retirement Process* booklet before completing this form and send the completed form to Colorado PERA 90 days before your retirement date. This form may also be completed online by logging onto your account and using your User ID and password.

Member Information

❑ *Check if your address is new*

Name _____
Last First MI

Address _____
Street, Route, or Box Number City State ZIP Code

Birthdate ____/____/____ Home Phone (____) _____

Cell Phone (____) _____ Email Address _____

Sign up for electronic delivery of PERA information? ❑ Yes ❑ No

Employer _____ Position _____

Spouse's Name _____ Spouse's SSN _____

Spouse's Birthdate ____/____/____ Spouse through: ❑ Marriage ❑ Civil Union

Retirement Date

Your retirement date is the first day of the month after your last day on the job or last day of any leave used (if applicable), whichever is later.

_____ 1, _____
Month Year

Benefit Option Selection

Choose only one Option, complete the requested information, and sign at the bottom. To designate your estate, trust, or charity as your named beneficiary, print "estate" or the name of the trust or charity, followed by the name of the executor/trustee in the blank provided for "Named Beneficiary" below. To designate more than one person as a named beneficiary, see the reverse side to list additional named beneficiaries. Submitting this form cancels and replaces all of your previous beneficiary designations. To continue any previous beneficiary designations, you must fully list all named beneficiaries on this form.

If you elect Option 1, indicate your named beneficiary below.

See page 7 for definitions of Option 1 and Named Beneficiary

❑ **Option 1**

Named Beneficiary _____ SSN _____

Address _____
Street, Route, or Box Number City State ZIP Code

If you elect Option 2 or 3, indicate your cobeneficiary and named beneficiary below. Your cobeneficiary cannot be the same as your named beneficiary because your named beneficiary will only receive a lump-sum payment of any remaining Defined Benefit (DB) Plan account balance in the event that you and your cobeneficiary die.

See page 7 for definitions of Options 2 and 3 and Cobeneficiary

❑ **Option 2** ❑ **Option 3**

Cobeneficiary _____ SSN _____

Birthdate _____ ❑ Cobeneficiary is a Supplemental Needs Trust
Month/Day/Year

Address _____
Street, Route, or Box Number City State ZIP Code

Named Beneficiary _____ SSN _____

Address _____
Street, Route, or Box Number City State ZIP Code

Sign Here → **Member Signature** _____ **Date** _____

(Continued on reverse)

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Your Name _____ **SSN** _____

Additional Named Beneficiaries

Your remaining DB Plan account (if any) will be divided equally among all of your named beneficiaries after your death

Complete this section if you want to list more than one named beneficiary. **You must sign and date below or your additional named beneficiaries will not be valid.**

Named Beneficiary _____ SSN _____

Address _____
Street, Route, or Box Number City State ZIP Code

Named Beneficiary _____ SSN _____

Address _____
Street, Route, or Box Number City State ZIP Code

Named Beneficiary _____ SSN _____

Address _____
Street, Route, or Box Number City State ZIP Code

Sign Here →
If you listed additional named beneficiaries

Signature _____ **Date** _____