National Life Group®

**National Life Insurance Company®**
**Life Insurance Company of the Southwest®**

# State of Hawaii
# PTS Deferred Compensation Retirement Plan
# Name, Address and Beneficiary Change

**For Part-Time, Temporary and Seasonal/Casual Employees of the State of Hawaii PTS Deferred Compensation Retirement Plan ("PTS Plan").**

Your Employer has automatically enrolled you in their FICA Alternative Retirement Plan, also known as the PTS Plan. The PTS Plan is only available to qualifying governmental employees. Each pay period, 7.5% of your gross compensation ("Deferred Compensation") will be deducted from your paycheck on a pre-tax basis in place of the Social Security (FICA) taxes, and placed in an interest-bearing PTS Plan account. Unlike the money taken out for Social Security, the money in your individual PTS Plan account - contributions plus earned interest - is returned to you when you leave State employment.

You may monitor the growth of your retirement fund. Benefits under the PTS Plan are to be determined as if your Deferred Compensation were funded 100% to a Life Insurance Company of the Southwest (LSW) Deposit Administration Contract. All of your contributions earn interest and the interest rate is guaranteed to be at least 1% at all times. When you qualify to receive benefits under the PTS Plan, you will generally receive the sum of your contribution plus interest, less any applicable tax withholding.

An independent administrator tracks each employee's account and handles the PTS Plan's record keeping. You will receive an account statement at least once each year.

You may designate a beneficiary in writing for benefits payable to you. Otherwise, your beneficiary will be determined in accordance with the written PTS Plan document. You must change your beneficiary as provided in this form if you do not want your benefits to be paid in this manner.

The PTS Plan Document is available for your review. Your rights and those of your beneficiary(ies), and the Employer's obligation under the Plan are set forth in the Plan Document. The terms, conditions and provisions of the Plan are hereby incorporated into this Change Form. Information contained in your Employer's payroll records will be used for the PTS Plan purposes unless you provide different information below and send it to Comprehensive Financial Planning (CFP) at the address shown on the reverse side of this form. If you have any questions, please call CFP at the number shown on the reverse side of this form.

**IMPORTANT NOTE:** IF YOU ARE AN ACTIVE PTS PARTICIPANT WHO IS MAKING CONTRIBUTIONS INTO THE PLAN AND THE ADDRESS PROVIDED ON THIS FORM IS DIFFERENT FROM THE ADDRESS IN OUR SYSTEM, WE WILL **NOT** UPDATE YOUR ADDRESS. PLEASE UPDATE YOUR ADDRESS THROUGH YOUR DEPARTMENTAL HUMAN RESOURCES OFFICE AND RETURN THIS FORM AFTER HUMAN RESOURCES HAS UPDATED YOUR INFORMATION.

## 1. Participant Information (This Section is Required)

☐ **Check here if requesting to change address**

☐ **Active PTS Eligible Employee** ☐ **Inactive PTS Eligible Employee with an account balance**

Employee Name: *(Last, First, Middle)* _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Social Security No: _____ Date of Birth: _____

Best Contact Number: _____ Work Phone: _____

Email: _____

## 2. Beneficiary Designation (Complete For Change in Beneficiary)

The designation(s) below revoke any prior designation(s) which are in effect for this Plan and will remain in effect until such time as revoked by me in writing. I understand that absent a written designation any benefits that become payable to me will be paid in accordance with the written Plan document. I further understand that nothing in this Agreement shall be construed as providing benefits that are not payable under the Plan, and I hereby affirm my understanding of the items listed above.

Please duplicate this page if you have more than two beneficiaries to submit in either category. Duplicate page(s) must also be signed and dated.

**Primary Beneficiary(ies) - These are the individual(s) who will receive your account balance upon your death.**

Name: _____ Relationship: _____ _____ %

Mailing Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Social Security No: _____

Name: _____ Relationship: _____ _____ %

Mailing Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Social Security No: _____

**Total: _____ %**

**(All Primary Designations MUST equal 100%)**

**Optional Contingent Beneficiary(ies) - These are the individual(s) who will receive your account balance upon your death in the event the Primary Beneficiary(ies) is/are deceased.**

Name: _____ Relationship: _____ _____ %

Mailing Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Social Security No: _____

Name: _____ Relationship: _____ _____ %

Mailing Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Social Security No: _____

**Total: _____ %**

**(All Contingent Designations MUST equal 100%)**

## 3. Name Change (Please include legal documentation showing name change)

From: _____ To: _____

Reason for Change: ☐ Marriage ☐ Divorce ☐ Other _____

## 4. Signature and Date (REQUIRED)

Participant's Signature: _____ Date: _____

## Please send this completed form to Comprehensive Financial Planning or contact us with any questions:

Comprehensive Financial Planning, Inc/LSW
1314 S. King Street, Suite 321
Honolulu, HI 96814
Email: info@comfinplan.com
Phone: 808-596-7006
Fax: 808-591-1109
For Neighbor Islands: 800-600-7167