Important Forms for Retirees and Surviviors

Change of Information Form 501

SERS
State Employees' Retirement System
srs.illinois.gov

2101 South Veterans Parkway
P.O. Box 19255
Springfield, IL 62794-9255

217-785-7444
Email: sers@srs.illinois.gov
Fax: 217-524-6975

Change of Information Form

This form may be used by benefit recipients only when making address or name changes.

Check the box that applies to your status with SERS. Please print or type all information below.

☐ Pension ☐ Survivor ☐ Disability ☐ Inactive ☐ QILDRO payee

Check the box to indicate what information is changing (check all that apply).

☐ Name change* ☐ Address change ☐ Email address

**Note: If you are completing for a name change, a photocopy of one of the following documents is required with this form: Marriage certificate, divorce decree (first page, name change section and page with judge's signature) or court order.*

Section 1 - Residential Address

Member information

Name *(Last, first, middle)*

Residential address *(Street) (No P.O. Box)*

(City, State, Zip)

Email address

Effective date of change

SSN *(last 4)* **or Member ID**

Date of birth

Phone number(s)

(H)

(C)

Section 2 - Mailing Address

If same as residential address, mark this box. ☐

Complete the following only if you wish to receive your mail at a location other than your residential address.

Name *(if POA/Guardian, attach corresponding document unless prev. submitted.)*

Mailing address *(Street)*

(City, State, Zip)

Email address

If POA or guardian, provide phone number

By signing below, I certify this information is correct and that I am aware that knowingly making a false statement or falsifying a record in an attempt to defraud SERS is a class 3 felony. I understand that if the SERS Board of Trustees has a reasonable suspicion that an attempt has been made to defraud SERS, it is required to report the matter to the appropriate State's Attorney for investigation.

Member signature **Date**

(Digital Signatures are NOT accepted)

501 (R-02/24)

Power of Attorney/Guardian needs to complete section 2, if applicable. SERS only accepts Power of Attorney for Property.

Direct Deposit
Same Bank Form 3867

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217-785-7444
Email: voucheringsection@srs.illinois.gov
Fax: 217-524-9039

Direct Deposit Account Number Change at the Same Bank Request

For use when current routing number remains unchanged

Member/payee information

Name *(Last, first, middle)*

SSN *(last 4)* **or Member ID**

Address *(Street)*

Phone number(s)

(H)

(City, State, Zip)

(C)

Email address

Financial Institution information

Financial institution name

Account holders name(s)

New Account Type

☐ Checking account ☐ Savings account

Routing Number *(must be unchanged in order to proceed)*

Previous Account Number

New Account Number

By signing below, I certify this information is correct and that I am aware that knowingly making a false statement or falsifying a record in an attempt to defraud SERS is a class 3 felony. I understand that if the SERS Board of Trustees has a reasonable suspicion that an attempt has been made to defraud SERS, it is required to report the matter to the appropriate State's Attorney for investigation.

Member signature _____ **Date** _____

A digital signature will not be accepted

Joint account holder signature ***(if any)*** _____ **Date** _____

(Also includes Power of Attorney – must attach document, or legal guardian – must attach court order)

Initial Direct Deposit Form 3967-initial (For Members without Direct Deposit)

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Initial Direct Deposit Agreement for Benefit Payments

Member/Payee Information

Name *(Last, first, middle)*

SSN *(last 4)* **or Member ID**

Address *(Street)*

Phone number(s)

(H)

(City, State, Zip)

(C)

Personal Email address

Signature

I, the above-designated payee, am receiving a monthly benefit from SERS. I hereby authorize SERS to forward such payments by electronic fund transfer to the financial institution indicated below, and I hereby authorize the financial institution to credit the amounts of those payments to the account listed below. This authority is to remain in full effect until my death or the end of my eligibility period, or until SERS has received written notice from me of its termination (provided the notice is submitted in a time and manner that allows SERS to act on the termination request).

I hereby acknowledge that my monthly benefits terminate at the end of the month of my death or my eligibility period. Accordingly, I agree that if any benefit payments to which I am not entitled shall have been received by my financial institution, I or we (if my account is a joint account) hereby authorize and direct my financial institution to refund the same to SERS and charge such refund payments to the account listed below, or to the extent money has been withdrawn from the account listed below by any other of the undersigned, to charge such refund payments to any other account which we, individually or jointly, may have in such financial institution. I further direct my financial institution to provide SERS with the names and addresses of all individuals that are joint account holders as of the date that the request is submitted by SERS. I or we (if my account is a joint account) further agree to hold harmless my financial institution for any action taken pursuant to or in compliance with this depository agreement.

By signing below, I certify this information is correct. I am aware that, under the Illinois Pension Code (40 ILCS 5/1-135), any person who knowingly makes any false statement or falsifies or permits to be falsified a record in an attempt to defraud SERS is guilty of a Class 3 felony. I understand that, if the SERS Board of Trustees has a reasonable suspicion that an attempt has been made to defraud SERS, it is required to report the matter to the appropriate state's attorney for investigation.

Member signature _____ **Date** _____

(Also includes Power of Attorney – must attach document, or legal guardian – must attach court order. A digital signature will not be accepted)

Joint account holder signature *(if any)* _____ **Date** _____

Financial Institution Acceptance *(This portion must be completed by the financial institution)*

The undersigned, on behalf of the financial institution below, hereby accepts the depository agreement as set forth above and verifies the signatures of all persons having an interest in the account.

Financial institution name

Account holders name(s)

Address *(Street)*

Branch designation *(if applicable)*

(City, State, Zip)

Phone number

☐ Checking account ☐ Savings account

ACH Routing number | | | | | | | | | |

Account number | | | | | | | | | | | | | | | | | |

Signature and title of authorized financial institution official

Date

Direct Deposit
Different Bank Form 3967

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Fax: 217-524-9039

Direct Deposit Agreement for Benefit Payments

Member/Payee Information

Name *(Last, first, middle)*

SSN *(last 4)* **or Member ID**

Address *(Street)*

Phone number(s)

(H)

(City, State, Zip)

(C)

Home Email address

Prior ACH Routing number* | | | | | | | | | Prior Account number* | | | | | | | | | | | | | | | | | |

**You only need to provide this information if you are changing your direct deposit account to a new financial institution.*

Signature

I, the above-designated payee, am receiving a monthly benefit from SERS. I hereby authorize SERS to forward such payments by electronic fund transfer to the financial institution indicated below, and I hereby authorize the financial institution to credit the amounts of those payments to the account listed below. This authority is to remain in full effect until my death or the end of my eligibility period, or until SERS has received written notice from me of its termination (provided the notice is submitted in a time and manner that allows SERS to act on the termination request).

I hereby acknowledge that my monthly benefits terminate at the end of the month of my death or my eligibility period. Accordingly, I agree that if any benefit payments to which I am not entitled shall have been received by my financial institution, I or we (if my account is a joint account) hereby authorize and direct my financial institution to refund the same to SERS and charge such refund payments to the account listed below, or to the extent money has been withdrawn from the account listed below by any other of the undersigned, to charge such refund payments to any other account which we, individually or jointly, may have in such financial institution. I further direct my financial institution to provide SERS with the names and addresses of all individuals that are joint account holders as of the date that the request is submitted by SERS. I or we (if my account is a joint account) further agree to hold harmless my financial institution for any action taken pursuant to or in compliance with this depository agreement.

By signing below, I certify this information is correct. I am aware that, under the Illinois Pension Code (40 ILCS 5/1-135), any person who knowingly makes any false statement or falsifies or permits to be falsified a record in an attempt to defraud SERS is guilty of a Class 3 felony. I understand that, if the SERS Board of Trustees has a reasonable suspicion that an attempt has been made to defraud SERS, it is required to report the matter to the appropriate state's attorney for investigation.

Member signature _____ **Date** _____

(Also includes Power of Attorney – must attach document, or legal guardian – must attach court order. A digital signature will not be accepted)

Joint account holder signature *(if any)* _____ **Date**_____

Financial Institution Acceptance *(This portion must be completed by the financial institution)*

The undersigned, on behalf of the financial institution below, hereby accepts the depository agreement as set forth above and verifies the signatures of all persons having an interest in the account.

Financial institution name

Account holders name(s)

Address *(Street)*

Branch designation *(if applicable)*

(City, State, Zip)

Phone number

☐ Checking account ☐ Savings account

ACH Routing number | | | | | | | | | |

Account number | | | | | | | | | | | | | | | | | |

Signature and title of authorized financial institution official

Date

_____ _____

Death Benefit Beneficiary Designation Form 101

SERS
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P.O. Box 19255
Springfield, IL 62794-9255

217-785-7444
Email: sers@srs.illinois.gov

Reset Form

Death Benefit Beneficiary Designation

Refer to instructions on opposite page. Type or print in ink.

Member information

Name *(Last, first, middle)*

SSN *(last 4)* **or Member ID**

Address *(Street, City, State, Zip)*

Phone number

Any death benefits payable by State Employees' Retirement System shall be paid in EQUAL SHARES to the following beneficiaries who survive me.

PRIMARY

Beneficiary name *(last, first, middle initial)*	**Street Address**	**SSN** *(last 4 digits) (optional)*
Relationship / Phone number	**City, State, Zip code**	**Date of Birth** *(MM/DD/YYYY)*

SECONDARY

Beneficiary name *(last, first, middle initial)*	Street Address	SSN *(last 4 digits) (optional)*
Relationship / Phone number	City, State, Zip code	Date of Birth *(MM/DD/YYYY)*

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Member signature _____ **Date** _____

A digital signature will not be accepted

Important Reminders for the Death Benefit Beneficiary Designation Form

- Keep current
- Name and address change
- How you identify – spouse, sons, daughters, etc.
- Minors/Guardians
- If no beneficiary listed, your estate is your beneficiary
- Changing SERS beneficiary form
  - **Does not change:**
    - Life insurance
    - Deferred Compensation

Other Important Contacts for Updating Beneficiaries

- State Employees' Retirement System
  217-785-7444
  srs.Illinois.gov
  sers@srs.Illinois.gov

- CMS Deferred Compensation
  800-442-1300 ext. 3
  217-782-7006

- Empower
  833-969-4532
  myillinoisdcplan.com