



Important Forms for Retirees and Survivors

Change of Information Form 501





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

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

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

Name of Member _____

Check the box to indicate what information is changing.

SSN (last 4) or Member ID _____

- Name change*
 Address change
 Email address
 Phone Number

**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) _____

Effective date of change _____

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

SSN (last 4) or Member ID _____

(City, State, Zip) _____

Date of birth _____

Personal email address _____

Phone number(s) _____

(H) _____

(C) _____

Section 1 - Residential Address

Member information

Name *(Last, first, middle)*

Effective date of change

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

SSN *(last 4)* or Member ID

(City, State, Zip)

Date of birth

Personal email address

Phone number(s)

(H)

(C)

Section 1 is the physical residential address of the member, even if the member has a POA or guardian.

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)*

If POA or guardian, provide phone number

(City, State, Zip)

Email address

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

(Digital Signatures are NOT accepted)

Date

501 (R-10/25)

The member's Power of Attorney or Guardian needs to complete section 2, if applicable. SERS will only accept Power of Attorney for Property (no medical).



Direct Deposit

Same Bank Form 3867



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

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)

(City, State, Zip)

(H)

(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 _____

A digital signature will not be accepted

Date _____

Joint account holder signature *(if any)* _____

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

Date _____



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



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

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

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)

(City, State, Zip)

(H)

(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



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

217-785-7444
Email: voucheringsection@srs.illinois.gov
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)

(City, State, Zip)

(H)

(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

No other form can be accepted
in lieu of the SERS Direct
Deposit fully completed and
signed by the member and
financial institution official.



Death Benefit Beneficiary Designation Form 101

SECONDARY

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

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

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