

**HOUSING AGENCY RETIREMENT TRUST**  
**NOTICE OF CHANGES FORM #160**  
**(MARK APPLICABLE BLOCKS WITH X)**

**1.  CORRECTION TO SOCIAL SECURITY NUMBER, DATE OF BIRTH, DATE OF HIRE, OR DATE OF PARTICIPATION**

Correct Social Security No. \_\_\_\_\_ Correct Date of Birth \_\_\_\_\_  
Correct Date of Hire \_\_\_\_\_ Correct Date of Participation \_\_\_\_\_

**2.  CHANGE OF VOLUNTARY AFTER-TAX CONTRIBUTION PERCENTAGE OR AMOUNT**

- Discontinue Voluntary After-Tax Contributions effective \_\_\_\_\_, 20\_\_\_\_  
 Begin Voluntary After-Tax Contributions effective \_\_\_\_\_, 20\_\_\_\_

**Complete One:** Start deducting \_\_\_\_\_% of my basic compensation, or \$ \_\_\_\_\_ per month.

**I understand that I may change the percentage or dollar amount or stop voluntary contributions entirely as of the first day of any month.** I also understand that if I desire to withdraw any amount from my voluntary contribution account, I may do so. The amount of this withdrawal cannot exceed the total value of my voluntary account balance. If I select a percentage above, my contribution will change whenever I have a salary change. If I select a dollar amount, it will remain the same unless I submit a change. I understand these additional contributions are subject to the following maximum IRS individual limit: **For calendar year 2018, the total of all contributions made to the Plan each year either by me or by my employer on my behalf cannot exceed whichever is smaller: \$55,000 or 100% of my annual salary. (The \$55,000 limit will be increased by the IRS each year after 2018.)**

**3.  DEFERRED RETIREMENT**

My employer has requested that I continue my employment beyond my normal retirement date, and I consent to do so.

- I wish to continue my required contributions. I understand my employer will continue contributing to the Plan for me  
 I wish to discontinue my required contributions to the Plan. I understand my employer will also discontinue contributions to the Plan for me.

**4.  CHANGE OR CORRECTION OF NAME (Review Your Beneficiary Designation. To Make A Change Use FORM #140)**

It is hereby requested that the name of the  Employee\*  Beneficiary  Other  
appearing in the Plan's file as \_\_\_\_\_  
be changed to \_\_\_\_\_ because of \_\_\_\_\_

**\*Important - If your name is changing, please notify your payroll representative to ensure they change your name on the retirement billing spreadsheet, otherwise it will revert back to your previous name.**

**5.  LEAVE OF ABSENCE Effective Date of Leave \_\_\_\_\_, 20\_\_\_\_**

A temporary suspension of contributions to this Retirement Plan because of:

- Military Leave  Pregnancy  Illness or injury  Other \_\_\_\_\_

During this leave of absence, the employee will not be receiving any compensation from this participating employer.

**IMPORTANT:** If my agency has Supplemental Death Benefit coverage, will it be kept in force?  Yes  No

**6.  RETURN FROM LEAVE OF ABSENCE Effective Date of Return \_\_\_\_\_, 20\_\_\_\_**

We hereby request reinstatement in this Plan as he/she has actively returned to work.

**ALL INFORMATION LISTED BELOW MUST BE COMPLETED**

Plan #: 598 \_\_\_\_\_ Employee's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Employee's Name (Please Print): \_\_\_\_\_  
Last First Middle

**I certify that this information is correct.**

Signed at (City, State) \_\_\_\_\_ this the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
Month Year

\_\_\_\_\_  
Name of Employer

\_\_\_\_\_  
Signature of Agency Authorized Official Required

\_\_\_\_\_  
Signature of Employee  
(Not Required for sections 5 & 6)

Agency keep original, employee keep a copy and fax form to: 1-973-712-7489  
Housing Agency Retirement Trust, c/o ADP Retirement Services, PO Box 22669, Louisville, KY 40252-0669  
PHONE: 1-800-798-2044