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 2019, 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: $56,000 or 100% of my annual salary. (The $56,000 limit will be increased by the IRS each year after 2019.)**

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

DEPT = RKOPSHART
TASK - CHGFORM

Print Form

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