CMS ILLINOIS
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES
P.O. Box 19208, Springfield, IL 62794-9208

STATE EMPLOYEES' DEFERRED COMPENSATION PLAN CHANGE FORM

Please type or print clearly in ink. Initial any corrections, additions, deletions or changes in pen. Fill out your name, social security number and payroll code number; complete additional information only if it reflects a change. For more information, call the Deferred Compensation Office at 1-800/442-1300, 1-217/782-7006 or TDD 1-800/526-0844.

Last Name	First	Middle Initial	Social Security Number
Street	City/State	Zip Code	Date of Birth
Agency or University		Office Phone Number	Home Phone Number
Work Address			Payroll Code No. _____ (See your pay stub)

SECTION A: TRANSACTION TYPE - Check Appropriate Box(es).

☐ Change in Deferral Amount (Complete Section B)

☐ Change of Mailing Address (Home)

☐ Name Change (State Previous Below)

_____

☐ Revocation (Complete Section C)

☐ Change of Work Address

☐ Transfer to New Agency _____ (Effective Date)

SECTION B: AMOUNT OF DEFERRAL - The minimum amount of deferral is $10 per pay period or $20 per month, whichever is greater. Indicate the amount to be deducted from each paycheck. Deferral changes can be effective no sooner than the first pay period of the next month.

☐ I hereby elect to participate in the State Employees' Deferred Compensation Plan. I authorize the State of Illinois to defer from my total compensation $_____ each pay period until my termination, modification or revocation of this amount, beginning the ☐ first or ☐ second pay period in _____ . (month) (year)

SECTION C: REVOCATION OF DEFERRAL

☐ I hereby revoke my election to participate in the State Employees' Deferred Compensation Plan, effective the pay period beginning the ☐ first or ☐ second pay period in _____. (month) (year)

READ THIS INFORMATION COMPLETELY BEFORE SIGNING

1. I am aware that the change in my deferral amount may be effective no sooner than the first pay period of the next month.
2. I am aware that my deferrals will continue to be invested as previously instructed, and that if I wish to make an investment allocation change I may do so by calling the Plan's recordkeeper (T. Rowe Price) at 1-888-457-5770.
3. I am aware that my revocation may be effective immediately following approval by the Department.
4. I am aware that any Name, Address, or Agency change will be effective upon approval of this form.

Signature X_____ Date _____

Send this completed form to your Agency Liaison - or send directly to the Department of Central Management Services.

Liaison
Name_____ Agency_____

Date _____ Phone No._____

Approval of Deferred Compensation Office required before any transaction takes place.

Date _____ By _____

In compliance with the State and Federal Constitution, the Illinois Human Rights Act, the Americans with Disabilities Act and Section 504 of the Federal Rehabilitation Act, the Department of Central Management Services does not discriminate in employment, contracts, or any other activity.