

CO-OP RETIREMENT PLAN CHANGE OF PARTICIPANT NAME FORM

Participant's Former Name: _____ SSN: _____

Participant's NEW Name: _____

Participant Employer Name: _____

ADDRESS

Address: _____

City: _____

State: _____

Zip Code: _____

Phone: _____

E-mail: _____

Signature: _____ Date: _____

Printed Name: _____

Please Mail or fax this form to:

UNITED BENEFITS GROUP
PO BOX 169005
KANSAS CITY, MO 64116

Fax: 816-459-8750