ABA Retirement Funds

PLEASE NOTE THE FOLLOWING WHEN SUBMITTING PROGRAM FORMS

- Use **only one** of the following methods of delivery:

By Mail:
ABA Retirement Funds Program
P.O. Box 55072
Boston, MA 02205-5072

By Overnight Delivery:
ABA Retirement Funds Program
30 Braintree Hill Office Park
Braintree, MA 02184

By Email: ProgramForms@voyaplans.com

- If you are emailing a form, **DO NOT** mail the original, or the transaction will be processed twice.
- Email only **one** form at a time unless the forms are related and for the same participant, in the same plan.
- Forms received in good order via e-mail by **1 p.m. Eastern time** on a business day are considered to be received on that day. Forms received electronically after 1 p.m. Eastern time will be considered to be received on the next business day.
- Please do not "cc" any other email addresses when sending a form to the Program by email, as this causes the email to abort.
- The email should include a single document as an attachment, which does not require access to an external portal or link.
- There should be no instructions in the body of the email; the form should contain any additional instructions.
- If you are going to password-protect the form, please use only "abafunds" or Abafunds*1."

FORMS THAT CANNOT BE ACCEPTED VIA EMAIL

- If the form is being submitted to claim the assets in a deceased participant's account, the form and a certified copy of the death certificate **must be mailed** or sent by overnight delivery.
- If spousal consent is required, and the witness is a notary, the form **must be mailed** or sent by overnight delivery so that the notary seal can be confirmed.

Forms submitted in any other manner will be considered to be received "not in good order," which may cause a delay in processing the item.

Thank you for your cooperation so that we can best service your plan.

Note: after your email is received by the transaction processing group, you'll receive an auto reply with a "Task" confirmation number. If you do not receive an auto reply, please contact us. Plan Administrators should call **800.752.6313**. Participants should call **800.348.2272**.

ABA Retirement Funds

PARTICIPANT DATA CHANGE FORM

ABA Retirement Funds Program ("the Program")
P.O. Box 55072 • Boston, MA 02205-5072

Customer Contact Center: 800.348.2272
Website: www.abaretirement.com

Complete this form to change the name, employment status, address or marital status of the participant's data. The participant completes sections 2 and 3; then signs under section 4. The Authorized Plan Representative completes section 1, signs under section 4 and mails the original, signed form to the address shown above.

1. EMPLOYER INFORMATION

Program Plan Number: ___ ___ ___ ___ ___ ___ Employer Tax ID Number: ___ ___ – ___ ___ ___ ___ ___ ___ ___ IRS Plan Number: ___ ___ ___

Employer's Name: _____ Employer's Business Phone Number: (____)_____–_____

2. PARTICIPANT INFORMATION CURRENTLY ON FILE

Participant's Name: _____ Social Security Number: ___ ___ ___–___ ___–___ ___ ___ ___

Daytime Phone Number: (____)_____–_____ E-mail: _____

3. NEW PARTICIPANT INFORMATION

Please choose from the following options:

☐ **Name Change**
Please print clearly or type your new name: _____

Please attach a copy of the document effecting the change (e.g., marriage certificate, divorce decree)

☐ **Status Change**
If your employment status has recently changed, please indicate the change below:

☐ Terminated (enter date of termination ___ ___ / ___ ___ / ___ ___ ___ ___)
MONTH DAY YEAR

☐ Rehired (enter date of rehire ___ ___ / ___ ___ / ___ ___ ___ ___)
MONTH DAY YEAR

☐ **Address Change**

Enter your new address below:

Street Address: _____

City: _____ State: _____ Zip Code: _____

☐ **Marital Status Change***

☐ I have been married as of ___ ___ / ___ ___ / ___ ___ ___ ___ (attach copy of marriage certificate)
MONTH DAY YEAR

☐ I have become widowed as of ___ ___ / ___ ___ / ___ ___ ___ ___ (attach copy of spouse's death certificate)
MONTH DAY YEAR

☐ I have been divorced as of ___ ___ / ___ ___ / ___ ___ ___ ___ (attach copy of divorce decree)
MONTH DAY YEAR

4. SIGNATURES

The participant and Authorized Plan Representative certify that the information presented on this form is complete and accurate.

SIGNATURE OF PARTICIPANT *(not required for employment status changes)* DATE

SIGNATURE OF AUTHORIZED PLAN REPRESENTATIVE ON BEHALF OF THE EMPLOYER *(not required for address changes only)* DATE

*Participants in a full service plan may need to update their beneficiary(ies) by completing a Beneficiary Designation Form. Participants in an investment only plan who need to update their beneficiary(ies) should see their employer/plan sponsor.