CITY of KANSAS CITY, MISSOURI
EMPLOYEES' RETIREMENT SYSTEM
RETIRED EMPLOYEE
CHANGE of INFORMATION

DATE SUBMITTED: _____

NAME: _____ **SSN:** _____-____-_____

PHONE #: _____

CHANGE of ADDRESS and/or PHONE NUMBER

Old Phone #: _____ New Phone #: _____

Old Address: _____ New Address: _____

_____ _____

CHANGE of BENEFICIARY (AT LEAST 18 YEARS OF AGE)

From: _____ To: _____

SSN: _____ SSN: _____

Address: _____ Address: _____

_____ _____

CHANGE of INSURANCE COVERAGE

COMPANY: _____

_____ Medicare (Enclose Copy of Medicare Card)
_____ Retiree _____ Spouse

_____ Cancel Coverage
_____ Retiree _____ Spouse _____ Dependent

Effective Date: _____

_____ Request for verification of Pension Benefit

Send to: _____

_____

_____

Signature: _____

Return this form to: Retirement Division, 414 East 12th St, 10th Floor, Kansas City, MO 64106. 816.513.1928.