EQUITABLE

Equitable Retirement Vision®

Change of Participant Name or Address

For Assistance:
Customer Service Call (888) 370-8871

Express Mail:
Equitable Retirement Plan Services
801 Pennsylvania Ave Suite 219886
Kansas City, MO 64105-1407
Regular Mail:
Equitable Retirement Plan Services
PO Box 219886
Kansas City, MO 64121-9886
Fax:
(833) 674-0745

EQUITABLE FINANCIAL LIFE INSURANCE COMPANY (EFLIC)*

PLEASE PRINT

To expedite this transaction, you also have the ability to change your address on the Internet at www.equitable.com.

1. Employer Information

Name: _____ Unit Number: _____

2. Participant Information

Account # _____

Name: First _____ MI _____ Last _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ Email Address: _____

Mobile phone #: _____ Alternate phone #: _____

3. Name Change

Note: Please provide a copy of one of the following types of documentation. If your name was changed through a court or other legal entity, submit a copy of the document showing both your new and former names. If your name changed as a result of marriage, submit a copy of your marriage certificate.

Former Name: First _____ Middle/MI _____ Last _____

New Name: First _____ Middle/MI _____ Last _____

4. Mailing Address Change

Note: If the address change is for a foreign address you must also include IRS Form W-8BEN or W-9 with the completion of this form.

Previous Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Country (if foreign address): _____

New Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Country (if foreign address): _____

*The Equitable Retirement Vision® defined contribution program consists of a custodial account offered through Benefit Trust Company, within which plan participants' chosen mutual fund shares are held, as well as a group fixed annuity issued by Equitable Financial Life Insurance Company ("Equitable"). Equitable is solely responsible for meeting the obligations of the group fixed annuity contract.

E16118
(03/2025)

5. Signatures/Authorization

PLEASE SIGN AND DATE THIS FORM. This form must be signed by the Participant and forwarded to the address on the Form or sent by Fax. Changes on this Form will be processed on the business day the Form is received (if all required information is provided) in our Processing Office.

For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to guilty of a crime and may be subject to fines and confinement in state prison.

I certify, under penalty of perjury, that the information I have provided is true and correct.

Participant's Signature

Date