

**Option A - 50% Spouse**

**PART I - GENERAL INFORMATION AND INSTRUCTIONS - PLEASE READ CAREFULLY**

*Option A - 50% Spouse.* This option first provides a reduced monthly benefit to you for life - then 50% of that benefit will continue after your death for the lifetime of your current spouse. If you select this option, the state sponsored health coverage and the payment of any reimbursement of the Medicare part B normal premiums will be extended at the time of your death to your spouse for as long as the monthly benefit continues. If you are married, a spouse waiver of survivor benefits (Form CO-1047) will be required if you do not provide a lifetime guarantee for that spouse. If you retire and have not designated in writing the benefit payment option you would prefer or have not obtained the consent of your spouse, your benefit will be paid according to your marital status when you apply for retirement benefits. Benefit options are elected when retirement forms are signed.

**Your benefit payment option cannot be changed after retirement for any reason.** If your current spouse dies, or you divorce, you will continue to receive the reduced retirement allowance. If you divorce your current spouse, s/he will still receive the benefit payable after your death. In the event you remarry after the death or divorce of your current spouse, Option A is not transferable to your new spouse and you would continue to receive the reduced retirement allowance.

**Print or type this form in duplicate (2 copies) and keep one copy for your records.** Forward the original with your retirement application to the Retirement Services Division, 55 Elm Street, Hartford, CT 06106. A copy of your spouse's birth certificate and your marriage license must accompany this form.

**PART II - ELECTION OF OPTION A - DESIGNATION OF SPOUSE**

MEMBER'S NAME (Last)	First Name	M.I.	EMPLOYEE NO.	RETIREMENT DATE	SOCIAL SECURITY NO.
MEMBER'S ADDRESS (Street No., Name, City, State, Zip Code)					DATE OF MARRIAGE
SPOUSE'S NAME (Last)	First Name	M.I.	SPOUSE'S DATE OF BIRTH	SPOUSE'S SOC. SEC. NUMBER	

**PART III - DESIGNATION OF BENEFICIARY TO RECEIVE REFUND IF APPLICABLE**

**Beneficiary designated to receive remaining contributions and interest (if any) after the death of member and spouse.**

NAME (Last)	First Name	M.I.	SOCIAL SECURITY NUMBER
ADDRESS (Street No., Name, City, State, Zip Code)			RELATIONSHIP

**PART IV - AGREEMENT AND ACKNOWLEDGEMENT**

I understand that my signature on this form means that I will retire with Option A in force and effect unless I make a contrary option election prior to retirement. I acknowledge that prior to signing this Income Payment Election, I had opportunity to ask questions and obtain additional information from Retirement Services Division staff with regard to the effect of such an election on my retirement and retirement related benefits. **I further understand that no change in this income payment election can be made after my retirement for any reason, that is, I can never change this payment election and choose another payment option.**

SIGNATURE OF APPLICANT	DATE	TELEPHONE NUMBER
SIGNATURE OF WITNESS	DATE	TELEPHONE NUMBER

PRINTED NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE) OF WITNESS