MSRS Minnesota State Retirement System
MNDCP Minnesota Deferred Compensation Plan
HCSP Health Care Savings Plan

Banking Change Request Form

PLEASE PRINT LEGIBLY IN BLACK OR BLUE INK

Plan Number: (check all applicable)	
☐ 98945-01 MNDCP ☐ 98946-01 HCSP	
Plan Sponsor Name: **MSRS**	
Employer Name	MSRS Employer Number

1. Primary Contact Information

The Primary Contact is the person that Empower will contact if we have any questions or concerns and when the banking change is complete.

Primary Employer Contact Name (please print): _____ Title: _____

Email Address: _____ Telephone # and extension: _____

2. Automated Clearing House Account Authorization

Please accept this as formal notification that effective ____/____/____ ,
Month Day Year

Employer's Name _____ (the "Employer")
has engaged Empower Retirement to be the recordkeeper for the following plan(s):

☐ Minnesota Deferred Compensation Plan (MNDCP) 98945-01

☐ Health Care Savings Plan (HCSP) 98946-01

(The "Plan") as sponsored by Minnesota State Retirement System as the Plan Sponsor. The Plan Sponsor acknowledges that Empower Retirement is a non-discretionary recordkeeper and that the Plan Sponsor retains all responsibilities otherwise not delegated to Empower Retirement in a formal agreement.

To facilitate Empower Retirement's recordkeeping duties for the Plan, Empower Retirement and its affiliates are hereby authorized to access the Contractholder's designated account at the depository financial institution listed below to initiate debit transaction via the Automated Clearing House (ACH) for the Plan. Company agrees to notify its depository financial institution of this arrangement.

Depository/Financial Institution Information

Company's Depository/Financial Institution Name	
Complete Address	
Account Title	Account Type ☐ Checking ☐ Savings ☐ Money Market
Account Number	ABA Routing Number

3. Primary Employer Contact Signature

Authorized Signature: _____

Print Name: _____

Date: _____

Employer: Please complete and fax or email to MSRS.
Fax number (651) 297-5238
Email: msrspayrollsupport@msrs.us

The Plan Sponsor agrees to provide Empower Retirement with 30 days notice, prior to closing or changing this account.

Authorized Plan Representative:

Signature: _____ Print name: _____

Title: _____ Email: _____

Phone #: _____ Date: _____