IDAHO OPTIONAL RETIREMENT PLAN ELECTION FORM

Section 1 (to be completed by Applicant)

☐ New Enrollment ☐ Change ORP Carrier

Social Security Number
___ ___ ___-___ ___-___ ___ ___ ___

Date of Birth (MM-DD-YYYY)
___ ___-___ ___-___ ___ ___ ___

My selection for ORP carrier: ☐ TIAA-CREF ☐ VALIC

Employee's Signature ____________________________________

Name (please print) ____________________________________

Section 2 (to be completed by Employer)

Name of Institution ____

Effective Date (Date of Employment or Change): ___________________

I certify that this employee is eligible to participate in the ORP and that he/she intends to enroll with the carrier designated above.

Signature____ Date __________________

Name & Title____