



THE INDEPENDENCE CENTER – COLORADO
VETERAN DIRECTED CARE
RETIREMENT OPT-OUT FORM

INSTRUCTIONS: Please fill out all the information in Sections 1, 2 and 3. The Direct Care Worker must sign and date to be considered complete. Please submit completed form to ResilientSD:

Mail

10425 W. North Ave
Suite 345
Milwaukee, WI 53226

Email

Enrollment@Resilient-SD.com

SECTION 1: DIRECT CARE WORKER INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____

SECTION 2: VETERAN/AUTHORIZED REPRESENTATIVE INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

SECTION 3: AUTHORIZATION

I understand that I have not been enrolled in my employer’s retirement plan. I elect to opt-out of my employer’s retirement plan. I understand that opting out is effective immediately.

I understand that if I choose to opt in, I must contact my employer’s Financial Management Services provider, ResilientSD, to notify them of my decision to opt in.

Direct Care Worker Signature: _____ Date: _____

For any questions or concerns, please contact our office at: **855.275.3948**.