

CHANGE OF EMPLOYEE INFORMATION

****Please print or type all information****

I request that the information listed below be changed on County records:

NAME: _____ DEPARTMENT: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____ EMPLOYEE #: _____

Date of Birth: ____/____/____

ADDRESS/PHONE NUMBER/NAME CHANGE

**** When changing a name, address verification must be provided ** (social security card for name change) (utility bill, driver's license, etc. for address change)**

FORMER NAME/ADDRESS

NEW NAME/ADDRESS

FORMER TELEPHONE NUMBER

NEW TELEPHONE NUMBER

(____) _____ (____) _____

Check all that apply:

UPMC Highmark Vision Benefits of America Delta Dental

CHANGE IN DEPENDENT/SPOUSE STATUS

In order to add/remove dependents, the employee **must** provide original verification of the change (birth certificate, marriage license, adoption papers, social security card, death certificate, divorce decree or other official records.) **When removing a dependent, please provide their current address.**

DEPENDENTS NAME	ADDRESS	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY	ADD/REMOVE
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CHANGE IN EMERGENCY CONTACT

NAME OF CONTACT(S)	RELATIONSHIP	HOME PHONE #	WORK W/EXTENSION
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_____ (____) _____ (____) _____
_____ (____) _____ (____) _____

I verify that the above information is true and accurate.

SIGNATURE: _____

DATE: ____/____/____

Suzi Payroll IS (Mike/Rick)

6/23/14