



## EMPLOYEE CHANGE FORM

To keep all personnel records correct and up to date, I request that the following information is changed :

Name: \_\_\_\_\_  
Current Name New Name

Note: A copy of your social security card or some other legal document with the new name must be attached in order f

Address: \_\_\_\_\_  
Current Street / Apt. # Address New Street / Apt. # Address

\_\_\_\_\_

Current City, State, ZIP New City, State, ZIP

Telephone ( ) \_\_\_\_\_  
Current Phone Number New Phone Number

The Human Resources Department will make the above changes for the following records:

- Payroll/HR system
- Medical/Dental insurance
- Other insurances

You must notify the following:

- Your retirement fund
- Your Center Manager

\_\_\_\_\_

Print Name Employee Signature Effective Date (mm-dd-yy)

Office Use Only:			
<input type="checkbox"/> ADP	<input type="checkbox"/> Medical and/or Dental	<input type="checkbox"/> Unum	<input type="checkbox"/> Jefferson Pilot