



Employee Address/Name Change Form

Employee Name _____ Date _____ Ext. _____

Social Security # _____ ID # _____ Dept. _____

Classification: Administrator; Classified; CAST; Faculty: F/T P/T; Retiree; Student; Temporary

*New Name: _____

*New social security card must be presented to Human Resource Services.

New Address:

Home Address, City, State, Zip: _____

**Mailing Address, City, State, Zip: _____

**All District correspondence, including W-2s and paychecks, will be sent to this address.

New Phone Numbers:

Local/Home (____) _____ Is this your primary phone? Yes No

Cell Phone (____) _____ Is this your primary phone? Yes No

Preferred Email Address: _____

Emergency Contact Information:

1st Contact _____ Relationship: _____ Phone (____) _____

2nd Contact _____ Relationship: _____ Phone (____) _____

The following is to be completed only by benefits-eligible employees and retirees.

Notify the following insurance vendors of the address change. Changes noted are to supersede previously submitted Enrollment Applications.

Health Insurance:

Medical: Kaiser, Medical Record #: _____ OR Fringe Benefits Consortium/PacifiCare

Other: American Fidelity/125 Flex Spending Plan

*Address changes for the dental and vision plans are done through your doctor's office.

X _____
Employee/Retiree Signature

OFFICE USE ONLY

Send/fax changes to:

_____ Benefits Specialist: 1. _____ CONSORTIUM FX: (858) 569-5086

2. _____ AMERICAN FIDELITY: (800) 522-6343

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