



Employee Change Form

Name: _____

Effective
Date: _____

PLEASE NOTE: EMPLOYEES ARE RESPONSIBLE FOR MAKING CHANGES IN PAYLOCITY, WITH PERA, 24 HOUR FLEX and AFLAC.

TYPE OF CHANGE

Please check all that apply.

- ☐ Address
☐ Phone Number
☐ Email Address

- ☐ Name Change
*Please see below for additional
documentation that must be submitted with
your request.*

Please print clearly.

Address: _____

City: _____ State: _____ ZIP: _____

Phone: (_____) _____

Email address _____

Insurance Selections that require address changes :

- ☐ Healthiest You ☐ Cigna Health Insurance ☐ Eye-Med Vision
☐ Alpha Dental ☐ MetLife Dental

THE FOLLOWING CHANGES REQUIRE SUBMISSION OF A NEW W-4 AND COPY OF THE LEGAL DOCUMENTATION WITH THIS CHANGE REQUEST FORM.

Name Change:

This should be your name as it appears on your Social Security card. You must also include a copy of your Social Security card with this request in order for the change to be processed.

Original Name: _____

New Legal Name: _____

Employee
Signature: _____ Date: _____