



CHANGE OF PERSONAL INFORMATION

Fill in all applicable information and forward to Human Resources. Please print clearly.

Name: _____ Employee #: _____	Social Security #: _____
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NAME CHANGE

Name Changed to: _____

Reason for Name Change: _____

* Attach document supporting change.

STATUS/ADDRESS/PHONE CHANGE/EMAIL

Marital Status: () Single () Married () Divorced () Legally Separated

New Address: _____

Street, P.O. Box, Apt. #, Route

City

State

Zip

New Phone: () _____

*Your direct deposit advice will be emailed to this address.

Email Address: _____

EMERGENCY CONTACT INFORMATION CHANGE

Name: _____ Home Telephone: _____

Relationship: _____ Work Telephone: _____

Personnel Use Only

Entered by: _____

Date entered into MUNIS: _____



BENEFIT CHANGE FORM

City of Gulfport
 1410 24th Avenue
 Gulfport, MS 39501
 228.868.5831 office
 228.868.5833 fax

**This form is NOT to be used for any COBRA event.
 Use Benefit Termination Notice instead.**

GROUP NAME City of Gulfport			GROUP NUMBER Plan # 10609
EMPLOYEES LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER

<p>(1) <input type="checkbox"/> APPLICATION FOR ADDITION OF DEPENDENTS</p> <p>(2) <input type="checkbox"/> DELETION OF EMPLOYEE COVERAGE</p> <p>(3) <input type="checkbox"/> DELETION OF DEPENDENT COVERAGE: Must have qualifying event and provide documentation, unless deletion is done during open enrollment.</p> <p>Please list dependents after checking this box. Check appropriate Coverage box for each dependent.</p>	<p>EFFECTIVE DATE OF EVENT: _____</p> <p>EFFECTIVE DATE OF ADDITION/DELETION: _____</p> <p style="text-align: center;">CIRCLE TYPE OF EVENT</p> <p>(A) For eligible spouse – give date of marriage</p> <p>(B) For adopted child – give date of legal adoption or date appointed guardian – Attach copy of adoption or guardianship papers.</p> <p>(C) For child acquired by marriage – give date of marriage.</p> <p>(D) For birth of child – give date of birth and certificate of live birth (must be provided within 31 days of birth).</p> <p>(E) For loss of Job/Coverage – give date of loss of job- Provide Certificate of Insurance</p>
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EMPLOYEE AND/OR DEPENDENT INFORMATION
 COMPLETE FOR YOURSELF AND EACH DEPENDENT TO BE COVERED BY THE PLAN

FULL NAME	SEX M/F	DATE OF BIRTH			SOCIAL SECURITY NUMBER	COVERAGE REQUESTED
		MO	DAY	YEAR		
EMPLOYEE						<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1500 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision
SPOUSE						<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1500 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision
CHILDREN 1.						<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1500 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision
2.						<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1500 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision
3.						<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1500 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision
4.						<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1500 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision
5.						<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1500 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision
6.						<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1500 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision

(4) <input type="checkbox"/> CHANGE OF NAME: (must provide copy of social security card)	FROM:	TO:	
(5) <input type="checkbox"/> CHANGE OF ADDRESS:	FROM:	TO:	
(6) <input type="checkbox"/> TRANSFER TO NEW DIVISION:	FROM:	TO:	
(7) <input type="checkbox"/> OTHER CHANGE TO RECORD:	FROM:	TO:	

Employee Signature: _____ Date Signed: _____

Personnel Use Only

Entered By: _____ Date Entered into MUNIS: _____