



Commonwealth of Massachusetts
Employee Information Change Form

PLEASE PRINT CLEARLY AND SIGN AND DATE AT THE BOTTOM OF THIS FORM

Required Fields

Last Name	First Name	M.I.	Employee ID
Please provide a preferred contact number and time should we have any questions.			Department

Note: Changing information on this form is optional. Please skip any section you wish to leave unchanged.

ADDRESS (Leave mailing address blank if same as home address)

In accordance with Homeland Security regulations, employees with P.O. boxes must also list a home street address.

Home Address Effective Month: _____ Day: _____ Year: _____

Address Line 1	Address Line 2			
Address Line 3	City	State	Zip	County

Mailing Address Effective Month: _____ Day: _____ Year: _____

Address Line 1	Address Line 2			
Address Line 3	City	State	Zip	County

PHONE (Please check only one preferred number)

Business # _____ ext _____ Mobile # _____ ext _____
 Home # _____ ext _____ Fax # _____ ext _____
 Provide phone number and type if not listed above
 Phone # _____ ext _____ Phone Type _____

EMERGENCY CONTACT (contacts entered below will replace any emergency contacts currently in the system)

Primary

Name		Relationship		
Street Number & Name		City		
State	Zip	Home Phone	Cell Phone	Work Phone

Secondary (optional)

Name		Relationship		
Street Number & Name		City		
State	Zip	Home Phone	Cell Phone	Work Phone

For Human Resources Office Use Only

- HR/CMS, Benefits Card File Financial Accounting Label – Pers. File – (name change only)
 Payroll (name change only)

Update 05/14



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NAME (Changes require a copy of a government issued identification card or a record of a legal name change - e.g. marriage certificate)

New Name

Prefix	First Name	M.I.	Last Name	Suffix
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EMAIL ADDRESS

Home Email _____ Business Email _____

Provide an alternate email address and email type if not listed above

Email Address _____ Email Type _____

MARITAL STATUS (Changes require a copy of your certified marriage certificate)

Effective Month _____ Day _____ Year _____

Single Married Divorced Separated Widowed

PERSONAL INFORMATION

(Changes to date of birth require a copy of your birth certificate or government issued identification card)

Gender Male Female

Date of Birth Month _____ Day _____ Year _____

Smoker Status* Smoker Non-smoker

*Selecting "Non-smoker" certifies that you have been tobacco-free (have not smoked cigarettes, cigars or pipes nor used snuff or chewing tobacco) for the past 12 months or longer.

HIGHEST EDUCATION LEVEL (Changes require a copy of your transcript)

Less Than HS Graduate HS Graduate or Equivalent Some College Technical School
 2-yr College Degree Bachelor's Level Degree Some Graduate School Master's Level Degree
 Doctorate (Academic) Doctorate (Professional) Doctorate (Law Degree) Post-Doctorate

MILITARY STATUS (Changes require form DD 214 or ODEO certification for Vietnam Era Veteran status)

Not Indicated No Military Service Not a Veteran Active Reserve
 Inactive Reserve Afghanistan Veteran Desert Shield Veteran Desert Storm Veteran
 Disabled Veteran Iraq Veteran Operation Enduring Freedom Veteran Operation Iraq Freedom Veteran
 Other Protected Veteran Retired Military Vietnam Veteran Vietnam Era Veteran
 Recently Separated Veteran Armed Forces Srvs. Medal Veteran Special Disabled Veteran

Note: Employees making changes to their information are responsible for notifying other related parties, such as:

- Metro Credit Union: 1- 877-696-3876
- Deferred Compensation – Great West: 877-457-1900
- Dependent Care Assistance / Health Care Spending Account – Benefit Strategies: 1-888-401-3539 or www.benstrat.com
- Long Term Savings Bonds: Complete new savings bond card and remit to Personnel/Payroll Processing unit

AUTHORIZATION I authorize the Commonwealth to make the appropriate changes to my employee data as noted on this form.

Employee Signature

Date