

CHANGE OF NAME FORM – ACTIVE EMPLOYEES

TO: Jarrell ISD
Human Resources Department
P. O. Box 9
312 N. 5th Street
Jarrell, TX 76537

FROM: _____ (Name of Employee)

RE: Change of Name and/or Address for Benefit Plans

Please advise my benefit plans of my new name and/or address as follows:

EMPLOYEE SOCIAL SECURITY NUMBER: _____

MUST SUBMIT COPY OF SOCIAL SECURITY CARD TO PROCESS NAME CHANGE

EMPLOYEE NAME

OLD NAME: _____

NEW NAME: _____

NEW ADDRESS:

(Street)

(City) (State) Zip)

NEW HOME PHONE:

(Area Code) (Number)

This form should be sent to the following benefit plans in which I am enrolled:

- _____ Name of Health Plan: _____
- _____ Lincoln Dental
- _____ Superior Vision
- _____ Allstate (circle one): Cancner/Accident/Critical Illness
- _____ One America Disability
- _____ Lincoln Life Ins.
- _____ Health/Dependent Care Spending Accounts (Medical Reimbursement/TASC)
- _____ Texas Life Insurance
- _____ Health Savings Account (HSA Bank)
- _____ MASA Medical Transport Solutions
- _____ Teledoc

Employee Signature

Benefit Coordinator Signature

Date

Date

JARRELL ISD 512-746-2124 EXT. 1102
Agency & Phone Number