



# PERSONAL DATA CHANGE FORM

Plan Name: \_\_\_\_\_

## ORIGINAL PARTICIPANT INFORMATION

_____ _____ _____ - _____ _____ - _____ _____ _____	_____ _____ _____ / _____ _____ / _____ _____ _____	_____ _____ _____ / _____ _____ / _____ _____ _____	
Social Security Number	Date of Birth	Date of Hire	
_____ _____ _____ _____ _____ _____ _____ _____	_____	_____ _____ _____ _____ _____ _____ _____ _____	
First Name	MI	Last Name	
_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____			
Street Address			
_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	_____	_____ _____ _____ _____	_____ _____
City	State	Zip Code	+4

## CHANGES TO PERSONAL DATA

Only complete this section if changes to Personal Data have occurred. Enter only the changed information.

_____ _____ _____ - _____ _____ - _____ _____ _____	_____ _____ _____ / _____ _____ / _____ _____ _____	_____ _____ _____ / _____ _____ / _____ _____ _____	
Social Security Number	Date of Birth	Date of Hire	
_____ _____ _____ _____ _____ _____ _____ _____	_____	_____ _____ _____ _____ _____ _____ _____ _____	
First Name	MI	Last Name	
_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____			
Street Address			
_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	_____	_____ _____ _____ _____	_____ _____
City	State	Zip Code	+4

## PARTICIPANT AUTHORIZATION

Signature of Participant \_\_\_\_\_ Date \_\_\_\_\_

## AUTHORIZED EMPLOYER REPRESENTATIVE USE ONLY

Date of Hire \_\_\_\_\_ Date of Termination/Service Change \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Date of Rehire \_\_\_\_\_

Enrollment Status:  Active  Retired  Leave of Absence  Deceased  Rehired  Terminated  Disable Permanently

Payroll Status:  Hourly  Salaried  Non-resident alien  Leased  Union

Payroll Frequency:  Weekly  Bi-Weekly  Semi-Monthly  Monthly

Marital Status:  Single  Married  Separated  Divorced  Widowed

High Comp Code:  Not HC  5% Owner  Prior year compensation in excess of \$80,000.00

Federal Exemptions: \_\_\_\_\_

Key Employee:  Not Key  Officer  1% Owner  5% Owner  10 Largest Owners

Eligibility Status:  Eligible class of employment  Ineligible class of employment

I authorize the above transaction and acknowledge that the information provided herein is complete and accurate.

Signature of Plan Authorized Signer \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Plan Authorized Signer \_\_\_\_\_

**Please fax completed form to 601-914-2329 or mail to Dyatech, 805 South Wheatley Suite 600, Ridgeland, MS 39157. For assistance with forms, please contact our Customer Service Dept. at 866-651-4222, ext. 400.**