



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)

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	Work Phone

Secondary (optional)

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



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NAME (Changes require a copy of a government issued identification card or a record of a legal name change)

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)

<input type="checkbox"/> Less Than HS Graduate	<input type="checkbox"/> HS Graduate or Equivalent	<input type="checkbox"/> Some College	<input type="checkbox"/> Technical School
<input type="checkbox"/> 2-yr College Degree	<input type="checkbox"/> Bachelor's Level Degree	<input type="checkbox"/> Some Graduate School	<input type="checkbox"/> Master's Level Degree
<input type="checkbox"/> Doctorate (Academic)	<input type="checkbox"/> Doctorate (Professional)	<input type="checkbox"/> Doctorate (Law Degree)	<input type="checkbox"/> Post-Doctorate

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

<input type="checkbox"/> Not Indicated	<input type="checkbox"/> No Military Service	<input type="checkbox"/> Not a Veteran	<input type="checkbox"/> Active Reserve
<input type="checkbox"/> Inactive Reserve	<input type="checkbox"/> Afghanistan Veteran	<input type="checkbox"/> Desert Shield Veteran	<input type="checkbox"/> Desert Storm Veteran
<input type="checkbox"/> Disabled Veteran	<input type="checkbox"/> Iraq Veteran	<input type="checkbox"/> Operation Enduring Freedom Veteran	<input type="checkbox"/> Operation Iraq Freedom Veteran
<input type="checkbox"/> Other Protected Veteran	<input type="checkbox"/> Retired Military	<input type="checkbox"/> Vietnam Veteran	<input type="checkbox"/> Vietnam Era Veteran
<input type="checkbox"/> Recently Separated Veteran	<input type="checkbox"/> Armed Forces Srvs. Medal Veteran	<input type="checkbox"/> 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