Employee Change Form

The information requested on this form is being collected pursuant to the Freedom of Information and Protection of Privacy (FOIP) Act, notably Sections 33, 34, 39 and 40, and is restricted to Division personnel responsible for administering Payroll and Benefits.

Name (as it presently appears on cheques):	
Employee Number:	Position: Teacher ☐ Support Staff ☐ Casual ☐
Date of Employment with Rocky View Schools:	

Please complete this form only in the specific areas requiring change to your Payroll and/or Personnel records

*Name Change:				* *Employee is to schedule an appointment with HR and have original picture identification and supporting document(s) to confirm legal name change.*
Do you wish to change your email address to reflect name change? ☐ Yes ☐ No				
Address Change:				City:
Postal Code:		Telephone:		
In case of emergency, contact:				
Emergency Telephone:				
List spouse and dependents with dates of birth:		Relationship to Employee	Birthdate YYYY/MM/DD	Student
Name:	☐ Male ☐ Female			☐ Yes ☐ No
Name:	☐ Male ☐ Female			☐ Yes ☐ No
Name:	☐ Male ☐ Female			☐ Yes ☐ No
Name:	☐ Male ☐ Female			☐ Yes ☐ No

BENEFIT CHANGES:

Provide reason for change:

SUPPLEMENTARY HEALTH CARE

SINGLE ☐ $64.16/month COUPLE ☐ $128.34/month FAMILY ☐ $192.50/month

NOT ELIGIBLE ☐ WAIVED ☐ (attach proof of spouse's coverage)

It is mandatory to provide the following information:

SPOUSE'S EMPLOYER: ____________________

BENEFIT COVERAGE: Single ☐ Family ☐ None ☐

DENTAL INSURANCE

Any changes to the Family Coverage without notification will result in conditions specified in the insurance policy.

SINGLE ☐ $57.50/month COUPLE ☐ $115.00/month FAMILY ☐ $172.50/month

NOT ELIGIBLE ☐ WAIVED ☐ (attach proof of spouse's coverage)

It is mandatory to provide the following information:

SPOUSE'S EMPLOYER: ____________________

BENEFIT COVERAGE: Single ☐ Family ☐ None ☐

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BENEFICIARY CHANGES:

LIFE INSURANCE, A.D. & D.

REVOCABLE BENEFICIARY: Surname: ______________________ Given Name: ___________________________

RELATIONSHIP: ____

EFFECTIVE DATE OF CHANGE: ____________________________

SIGNATURE: ____________________________________

TEACHERS' RETIREMENT FUND and LOCAL AUTHORITIES PENSION PLAN (Support Staff)

Change Forms will be supplied when requested or required

I hereby declare that I have read and understood the information contained on this form and the use of personal information and the information I have provided is correct. I authorize the changes necessary to appear on my Payroll and Personnel records. If contributions towards premiums are necessary, I also authorize the necessary deductions from my earnings.

SCHOOL: ____

SIGNATURE: _____________________________________ DATE: ____________________________________

If you have any questions regarding this request for personal information and the use of this information, please contact the Payroll Officer or the R.V.S. FOIP Coordinator at 403.945.4013.

Submit to the Benefits Department
Rocky View Schools Education Centre

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FOR OFFICE USE ONLY

ANNUAL SALARY:	EFFECTIVE DATE:
VERIFIED BY:	DATE:
PAYROLL ADJUSTMENT ☐	GREAT WEST LIFE INFORMED ☐