CHANGE OF NAME/ADDRESS FOR ERS

INSURANCE MULTIPURPOSE FORM
Employees Retirement System of Texas

Section A: Employee Data (Consult Benefits Coordinator for assistance)

National ID/SSN:: _____ Empl ID: _____ Date: _____ (MM/DD/YYYY)

Employee Name: _____ Gender ☐ M ☐ F Birthdate: _____ (MM/DD/YYYY)
(First, Middle, Last)

☐ Check if New Address

Mailing Address: _____ City. _____ State: _____ Eligibility County: _____ ZIP Code _____

Telephone Number _____ E-Mail Address: _____

Employee Name Change: _____

Agency Name: AMARILLO COLLEGE DeptID: 0952

Employee's Signature _____ Date Signed (MM-DD-YYYY) _____

ERS G1 1.180 (R09/02)

Keep a copy of this form for your files and return the original to your Benefits Coordinator