CITY OF GLENDALE - HUMAN RESOURCES

EMPLOYEE PERSONAL DATA CHANGE FORM

PLEASE PRINT CLEARLY OR TYPE - THIS FORM WILL BE USED FOR DATA ENTRY

Employee's Name: _____ Extension: _____
First Middle Last

Social Security #: _____ Employee #: _____

Job Classification Title: _____ Division/Sect: _____

Please Check One: ☐ Salaried ☐ Hourly ☐ Former Employee ☐ Retiree

Change Effective Date (Required Info): _____

☐ **NAME CHANGE / NEW NAME** (Note: Primary name requires that you present your original social security card to HR showing the new name)

☐ **Primary Name Change** **OR** ☐ **Preferred Name Change** (if preferred name is different from primary name)

New Primary Name: _____

New Preferred Name: _____

Employee's Former Name: _____

☐ **ADDRESS CHANGE / NEW ADDRESS** (Note: Indicate if the change is to your home address, your mailing address, or both)

☐ **Home Address Change**

Street Address: _____

City/State/Zip: _____

☐ **IMPORTANT**: Check this box if you want your mailing address to be the **same** as your home address; if not, indicate your mailing address below:

☐ **Mailing Address Change**

Street Address: _____ Email Address: _____

City/State/Zip: _____

☐ **PHONE NUMBER CHANGE / NEW PHONE NUMBER** (Note: Include area code)

Phone Number Type: ☐ Home: ☐ Business: ☐ Cellular:

List Phone Number: _____ _____ _____

☐ **MARITAL STATUS AND MARITAL STATUS DATE CHANGE** (Note: It is important to indicate the effective date above)

Change marital status to: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

☐ **MILITARY STATUS CHANGE**

Change military status to: ☐ Active Reserve ☐ Inactive Reserve

☐ **CITIZENSHIP STATUS CHANGE**

Change citizenship to: ☐ U.S. Naturalized ☐ Alien Permanent

☐ **EDUCATIONAL STATUS CHANGE** (Note: A copy of your degree is necessary to change your educational status)

Change education to: ☐ High School Graduate or Equivalent ☐ 2 Year College Degree
☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate

Salaried or Retired Employees Only: Check any plans you may be enrolled in so we can notify your provider(s). Please indicate "Not Sure" if you are unsure.

Health Plans: ☐ Blue Cross PPO ☐ CaliforniaCare ☐ Cigna ☐ Kaiser

Dental Plans: ☐ Guardian PPO ☐ Guardian HMO **OR** ☐ Not Sure

Employee's Signature & Date (Required): _____

(Note: You may e-mail this form in lieu of signing it by sending it from your City Outlook e-mail account to HREmployeeServices)

Employee to forward completed and signed form to Human Resources for processing

For Office Use Only: ☐ Data Entry ☐ Benefits ☐ Work Comp ☐ Employee's File CS-291 Revised 3/10/05