

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