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

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)

☐ Less Than HS Graduate ☐ HS Graduate or Equivalent ☐ Some College ☐ Technical School
☐ 2-yr College Degree ☐ Bachelor's Level Degree ☐ Some Graduate School ☐ Master's Level Degree
☐ Doctorate (Academic) ☐ Doctorate (Professional) ☐ Doctorate (Law Degree) ☐ Post-Doctorate

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

☐ Not Indicated ☐ No Military Service ☐ Not a Veteran ☐ Active Reserve
☐ Inactive Reserve ☐ Afghanistan Veteran ☐ Desert Shield Veteran ☐ Desert Storm Veteran
☐ Disabled Veteran ☐ Iraq Veteran ☐ Operation Enduring Freedom Veteran ☐ Operation Iraq Freedom Veteran
☐ Other Protected Veteran ☐ Retired Military ☐ Vietnam Veteran ☐ Vietnam Era Veteran
☐ Recently Separated Veteran ☐ Armed Forces Srvs. Medal Veteran ☐ 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
- Dependent Care Assistance / Health Care Spending Account – Benefit Strategies: 1-888-401-3539 or www.benstrat.com
- Deferred Compensation – Great West: 877-457-1900
- 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