EMPLOYEE INFORMATION
CHANGE REQUEST FORM

EMPLOYEE INSTRUCTIONS:
This form is to be completed only by the employee when a change needs to be made. To report changes for medical benefits (newborn, adoption, spouse's new medical insurance or loss of insurance, etc.) use the form "*Health Care Plan Change Request Form*" available from HR Office by calling 609-802-0855.

Employee First Name:_____Last Name:_____

Changes to be made: *Mark Choice*

☐ Employee Name* ☐ Spouse Name* ☐ Address ☐ Phone number ☐ Payroll e-mail

Need only to fill out blanks for changes marked above

**Employee Last Name:* _____*First*_____*Middle Initial*_____

**Spouse Last Name:* _____*First*_____*Middle Initial*_____

Address: Street_____City_____State_____Zip code_____

Phone Number: _____

Payroll e-mail: _____

☐ By checking this box I certify that I am a New Jersey Conference employee

**To make a name change, please provide copy of government issue ID with the new name.*

FOR OFFICE USE ONLY

CHANGES MADE IN:

[ ] APS [ ] e-Adv Personnel [ ] ARM Health Care [ ] Pastors Directory
[ ] Pastors District list (Cell Phone only) [ ] IT (For group emails only) [ ] Office staff was notified
[ ] SimpleBlast (cell phone only) [ ] e-Adventist Membership (email Eileen G.)

Completed by: Date: