



HARFORD COUNTY PUBLIC SCHOOLS

HUMAN RESOURCES OFFICE

102 S. Hickory Avenue
Bel Air, Maryland 21014
410-588-5225 ~ FAX: 410-588-5315

ADDRESS CHANGE/FAMILY STATUS CHANGE FORM

Submit to: **Human Resources Office**

Effective Date of Change: _____

All changes will be made on the information provided to us below. Please READ the form carefully. This form **CANNOT** be used to add or delete a dependent to your health or dental insurance or change a beneficiary. Contact the Human Resources-Benefits Office at (410) 588-5275 to obtain the proper forms.

Please check where applicable: Address Change Phone Number Change Name Change (NEW Social Security card required)

Please send me a W-4 form due to my **name change or change in state of residency**.

Employee ID #: _____ Social Security Number: _____

Name: _____
First Middle Name Last

Previous Last Name (if changing): _____ New Phone Number: _____

New Address: _____
Street & Apt. Number City State Zip + 4 County

Previous Address: _____
Street & Apt. Number City State Zip + 4 County

Current Position: _____ School/Office: _____

FAMILY STATUS CHANGE - Check all changes that apply:

You must provide proper documentation and complete a new enrollment form within 31 days of the family status change date before changes can be effective.

- **Marriage** **Divorce** *Attach copy of marriage certificate, NEW social security card, and dependent verification form or divorce decree*
- **Death of Spouse** *Attach copy of death certificate* **Death of Dependent Child**
- **Coverage Gained** **Coverage Terminated** **Under Spouse's Employer for:** Me Spouse Child
Attach verification from employer stating the type of coverage and effective dates
- **Birth** **Adoption of a Dependent Child**
Attach copy of birth certificate, hospital document, or legal adoption papers to the dependent verification form
- **Other (specify and provide documentation)** _____

Please check the benefits which need to be updated due to the above status changes:

HEALTH INSURANCE

BC/BS PPO Plus YES NO
BC/BS PPO Core YES NO
Blue Choice: YES NO

DENTAL INSURANCE

Delta Premier: YES NO
Delta PPO: YES NO

➤ LIFE INSURANCE - BENEFICIARY INFORMATION: YES NO

➤ FLEXIBLE SPENDING ACCOUNT: Healthcare Dependent Care

➤ PENSION/RETIREMENT SYSTEM - BENEFICIARY INFORMATION: YES NO

Is spouse employed by Harford County Public Schools? YES NO If yes, provide name, social security number and employee ID number:

Name/SS#: _____ Employee ID #: _____

The Board will not provide two insurance programs for any eligible employees or eligible members of their family.

The change in coverage must be consistent with family status change. Changes include, but are not limited to: increasing amounts in medical, dependent care; decreasing the amounts in medical, dependent care or both; changing from family to single or single to family medical coverage; withdrawing from the plan. **This change of election must be accompanied by the appropriate documentation for each of the above changes and submitted within 31 days of such change.** Under penalties of perjury, I hereby certify that (i) to the best of my knowledge, the Status Change indicated above resulted in me, my spouse, or dependent gaining or losing eligibility for medical or dental insurance coverage under the Plan, a plan sponsored by another employer by who I am employed or plan sponsored by the employer of my spouse or dependent, and (ii) the above election change is being made due to, and are consistent with the family status change indicated above.

Employee Signature _____

Date _____