

GettHealth MERP

EMPLOYEE INFORMATION CHANGE FORM

PLEASE FAX TO: 717-337-2081

Please Indicate All That Apply:

- CHANGE CURRENT NAME/ADDRESS/PHONE
- ADD DEPENDENT(s)
- REMOVE DEPENDENT(s)
- CHANGE CURRENT STATUS
- EMPLOYEE TERMINATION

As of Date:

GROUP NAME: _____ GROUP ID#: _____

SOCIAL SECURITY # EMPLOYEE NAME:

____-____-____ LAST FIRST MI

DATE OF BIRTH: ____/____/____ DATE OF HIRE: ____/____/____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE NUMBER: (____) _____ STATUS: SINGLE 2-PARTY FAMILY

DEPENDENT INFORMATION:

Name: _____ SSN: _____ DOB: _____

Name: _____ SSN: _____ DOB: _____

Name: _____ SSN: _____ DOB: _____

EMPLOYEE SIGNATURE: _____

EMPLOYER SIGNATURE (ONLY REQUIRED IF TERMINATING EMPLOYEE):
