CHANGE OF NAME/ADDRESS FORM – ACTIVE EMPLOYEES

TO: Department of Budget and Management
Employee Benefits Division
301 W. Preston Street
Room 510
Baltimore, Maryland 21201

FROM: ____________________________________(Name of Employee)

RE: Change of Name and/or Address for Benefit Plans

Active Employee: ________ **Contractual Employee:** ________

Please advise my benefit plans of my new name and/or address as follows:

EMPLOYEE SOCIAL SECURITY NUMBER______________________________

EMPLOYEE NAME

OLD NAME:______________________________

NEW NAME:______________________________

NEW ADDRESS ______________________________
(Street)

____
(City) (State) (Zip)

NEW HOME PHONE ( ) (-)
(Area Code) (Number)

This form should be sent to the following benefit plans in which I am enrolled:

- ________ Name of Health Plan: ______________________________
- ________ PCS Prescription Plan
- ________ United Concordia Dental
- ________ Dental Benefit Providers
- ________ Metropolitan Life Insurance
- ________ PA&D (Personnel Accident & Dismemberment)
- ________ Health/Dependent Care Spending Accounts

Employee Signature	Agency Benefits Coordinator Signature
Date	Date
Agency Name & Code	Telephone Number

Note: Payroll Change -of-Address Card MUST be sent to Central Payroll Bureau at the same time.

Revised 8/23/2001