

CHANGE OF NAME/ADDRESS FORM

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

FROM: _____ (Name of Employee/Retiree)

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

Active Employee: _____ **Satellite Employee:** _____ **Direct Pay:** _____ **Retiree:** _____

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

EMPLOYEE/RETIREE SOCIAL SECURITY NUMBER: _____

EMPLOYEE/RETIREE NAME:

OLD NAME: _____

NEW NAME: _____

NOTE: Legal proof of name change must be attached to this form.

NEW ADDRESS: _____
Street

City State Zip

NEW HOME PHONE #: _____

WORK PHONE #: _____ **CELL:** _____

EMAIL ADDRESS: _____

Employee/Retiree Signature

Agency Benefits Coordinator Signature
(Active employees only)

Date _____ Date _____

Telephone Number

Agency Name & Code

Note:

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

Retirees: Signed Change-of-Name or Address letter **MUST** be sent to the Maryland State Retirement Agency at the same time.

8/18/10