RESET PRINT SUBMIT

Lower Columbia College

Employee Change Form

RETURN COMPLETED FORM TO HUMAN RESOURCES

EMPLOYEE PROFILE

Employee Name: _____ Employee ID: _____

Phone: _____ Date Change is Effective: _____

Employee Type: Full-time: ☐ Part-time Hourly: ☐
Part-time Faculty: ☐ Part-time Student: ☐

PERSONNEL CHANGES

Change	New Information	
*Name Change: ☐	New Name: _____	*will require ID
Address: ☐	Street Address: _____	
	City, State, Zip: _____	
Phone Number: ☐	Home: _____	
	Cell or Other: _____	

For Benefit Employees only: Be sure to contact Human Resource Services **within 60 days** if you have any of the following changes outside of Open Enrollment. You must also complete a PEBB Medical/Dental Change form.

Marriage/ Divorce: ☐ Birth/ Adoption/ Legal Custody of Child: ☐ Waive Coverage: ☐

Add/Remove Dependents: ☐ Change in Other Medical/Dental Benefits: ☐ Loss of Other Medical Coverage: ☐

Additional Changes/Benefits Information

Please List Any Additional Changes in Benefits:

Please List Any Other Changes Not Listed Above:

Information on this form will be sent to HR and Payroll only.

Verification of Changes

_____ _____

Employee Signature Date

FOR OFFICE USE ONLY

Date HR Received: _____ *Date Sent to Payroll:* _____

Benefits Updated: _____ *Payroll Updated:* _____

10/12