



Commonwealth of Massachusetts

Employee Information Change Form

PLEASE PRINT CLEARLY AND SIGN AND DATE AT THE BOTTOM OF THIS FORM

Fax this form to the MassHR Employee Service Center

Fax: 617-248-0686 **Telephone:** 617-979-8500

Required Fields

Last Name	First Name	M.I.	Employee ID
Please provide a preferred contact number and time should we have any questions.			Department

Note: You may enter any and all information you wish to change. Please skip any section you wish to leave unchanged.

NAME CHANGE (Changes require a copy of a government issued identification card or a record of a legal name change)

New Name

Prefix	First Name	M.I.	Last Name	Suffix
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ADDRESS (Leave mailing address blank if same as home address)

Home Address	Effective Month:	Day:	Year:	
Address Line 1	Address Line 2			
Address Line 3	City	State	Zip	County

Mailing Address	Effective Month:	Day:	Year:	
Address Line 1	Address Line 2			
Address Line 3	City	State	Zip	County

PHONE (Please check only one preferred number)

☐ Business # _____ ext _____	☐ Mobile # _____ ext _____
☐ Home # _____ ext _____	☐ Fax # _____ ext _____

Provide phone number and type if not listed above

☐ Phone # _____ ext _____	Phone Type _____
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EMAIL ADDRESS

Home Email _____	Business Email _____
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Provide an alternate email address and email type if not listed above

Email Address _____	Email Type _____
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Note: Employees making changes to their information are responsible for notifying other related parties, such as:

- | | |
|--|--|
| • Metro Credit Union: 1- 877-696-3876 | • Metro Credit Union: 1- 877-696-3876 |
| • Dependent Care Assistance / Health Care Spending Account –
Benefit Strategies: 1-888-401-3539 or www.benstrat.com | • Dependent Care Assistance / Health Care Spending Account –
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MARITAL STATUS (Changes require a copy of your certified marriage certificate)

Effective Month _____ Day _____ Year _____
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

EMERGENCY CONTACT (contacts entered below will replace any emergency contacts currently in the system)

Primary

Name		Relationship	
Street Number & Name		City	
State	Zip	Home Phone	Work Phone

Secondary (optional)

Name		Relationship	
Street Number & Name		City	
State	Zip	Home Phone	Work Phone

PERSONAL INFORMATION (Changes to date of birth require a copy of your birth certificate or government issued identification card)

Gender ☐ Male ☐ Female
Date of Birth Month _____ Day _____ Year _____
Smoker Status* ☐ Smoker ☐ Non-smoker

*Selecting "Non-smoker" certifies that you have been tobacco-free (have not smoked cigarettes, cigars or pipes nor used snuff or chewing tobacco) for the past 12 months or longer.

HIGHEST EDUCATION LEVEL (Changes require a copy of your transcript)

☐ Less Than HS Graduate	☐ HS Graduate or Equivalent	☐ Some College	☐ Technical School
☐ 2-yr College Degree	☐ Bachelor's Level Degree	☐ Some Graduate School	☐ Master's Level Degree
☐ Doctorate (Academic)	☐ Doctorate (Professional)	☐ Doctorate (Law Degree)	☐ Post-Doctorate

MILITARY STATUS (Changes require form DD 214 or ODEO certification for Vietnam Era Veteran status)

☐ Not Indicated	☐ No Military Service	☐ Not a Veteran	☐ Active Reserve
☐ Inactive Reserve	☐ Afghanistan Veteran	☐ Desert Shield Veteran	☐ Desert Storm Veteran
☐ Disabled Veteran	☐ Iraq Veteran	☐ Operation Enduring Freedom Veteran	☐ Operation Iraq Freedom Veteran
☐ Other Protected Veteran	☐ Retired Military	☐ Vietnam Veteran	☐ Vietnam Era Veteran
☐ Recently Separated Veteran	☐ Armed Forces Srvs. Medal Veteran	☐ Special Disabled Veteran	

AUTHORIZATION I authorize the Commonwealth to make the appropriate changes to my employee data as noted on this form.

Employee Signature _____

Date _____