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

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 _____

EMAIL ADDRESS

Home Email _____ Business Email _____

Provide an alternate email address and email type if not listed above

Email Address _____ Email Type _____

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

- Metro Credit Union: 1- 877-696-3876
- Dependent Care Assistance / Health Care Spending Account – Benefit Strategies: 1-888-401-3539 or www.benstrat.com

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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