To be filled out by everyone

IMPERIAL VALLEY COLLEGE
CHANGE OF ADDRESS FORM

EMPLOYEE NAME:_____**G#**_____

SSN# XXX-XX - _____

OLD ADDRESS:

_____
Address

_____
City/State/Zip

_____
Phone Number

NEW ADDRESS:

_____
Address

_____
City/State/Zip

_____
Phone Number

CHANGE IN NAME: NO YES – New Name:_____

_____
Employee Signature

_____
Date

OFFICIAL USE ONLY

_____
Date changed in Human Resources

_____
HR Signature

_____
Date changed in Payroll

_____
Payroll Signature

To be filled out by PERS members

CalPERS Member Action Request Form

(Due to ICOE-District Financial Services within the earlier of 10days of qualifying event or with payroll prelist submittal)

Attached copy of Social Security Card and CalPERS Reciprocity Form is required

First Name	Middle Name	Last Name	Suffix

Social Security No.	Date of Birth	Gender	Phone Number
		☑ Female ☐ Male ☐ Unknown	☐ Home ☑ Cell ☐ Work

Mailing Address:	District Name (Division):
Street/P.O. Box:	
City:	Job Position/Title:
State: ZIP Code:	

Membership Date:	Original Hire Date:	Effective Date of Action:	Months Worked/Year	Months Paid/Year

Type of Action (check all boxes that apply for this **Effective Date)**:

A. ☐ **Appointment/Membership** (select qualification)

- ☐ Full-Time > 6months
- ☐ Part-Time for >= 20hrs for 1yr or more
- ☐ Indeterminate; 20hrs a week for 1yr or more
- ☐ 1000hrs or 125days in fiscal year
- ☐ Already a PERS Member

B. ☐ **Name Change**

Former Name:_____

C. ☐ **Address Change**

D. ☐ **Separation** (select reason)

Date:_____ Last day worked:_____

Unused Sick Leave Hours:_____

- ☐ Deceased Date:_____
- ☐ Layoff
- ☐ Permanent
- ☐ Military Leave
- ☐ Workers Comp Leave
- ☐ Maternity/Paternity Leave
- ☐ Retirement

Membership Information:

	Yes	No		Yes	No
Retired Annuitant	☐	☐	STRS position electing CalPERS	☐	☐
Subject to Social Security	☐	☐	PERS position electing CalSTRS	☐	☐
Subject to Survivor Benefits	☐	☐	Reciprocity	☐	☐

Form Completed by:

Name *Title* *Date* *Phone Number*

Official Use Only

Update ICSIS Membership Update MyCalPERS User:_____ Date:_____

CalPERS ID:

Save Print Reset

Address Change Request

AS 0786 (rev 10/13)

To be filled out for STRS members

CALSTRS
California State Teachers' Retirement System
P.O. Box 15275, MS 85
Sacramento, CA 95851-0275
800-228-5453
CalSTRS.com

Instructions

CalSTRS retired members, inactive members and benefit recipients may use this form to change the mailing address to which benefit payments and other CalSTRS correspondence is sent.

If you are a CalSTRS member currently working in the California public school system, you may use this form to change your mailing address. However, you are responsible for informing your CalSTRS employers of your address change.

You can also update your address and email online using your *my*CalSTRS account at CalSTRS.com.

Note: If your new address is outside of California or you are moving from another state to California, you may want to update your California state income tax withholding using your *my*CalSTRS account or the *Income Tax Withholding Preference Certificate* available on CalSTRS.com.

Check one of the following:

- ☐ Change mailing address for CalSTRS correspondence. I do not receive benefit payments at this time.
- ☐ Change mailing address for my benefit payments.
- ☐ Change my mailing address to the address listed below and continue sending my benefit payments to my financial institution.
- ☐ Change my mailing address to the address listed below. My payment is sent to my financial institution and the financial institution account number also needs to be changed. To change the financial institution account information, submit a new *Direct Deposit Authorization* form if your payment is sent by electronic funds transfer.
- ☐ Cancel my *Direct Deposit Authorization* and send my payments to the address listed below.
- ☐ Other (use back of form for additional space): _____

New Mailing Address (please print)

NAME (LAST, FIRST, INITIAL)

CLIENT ID OR SOCIAL SECURITY NUMBER

MAILING ADDRESS

DATE OF BIRTH (MM/DD/YYYY)

CITY | STATE | ZIP CODE

( ) HOME TELEPHONE

EMAIL ADDRESS

I authorize CalSTRS to change my mailing address.

SIGNATURE

DATE (MM/DD/YYYY)

Address changes require the member or benefit recipient's signature. Anyone else signing this form must include legal documentation that gives them authority to sign for the member or benefit recipient.

Allow up to 60 days for an address change to take effect. CalSTRS forms are available online at CalSTRS.com. For more information, call 800-228-5453.

Mail this form to: CalSTRS, P.O. Box 15275, MS 85, Sacramento, CA 95851-0275.

AS786

To be filled out by employees with health insurance through the District

Medical Benefits - CHANGE / TERMINATION FORM

ICSVEBA

EMPLOYEE INFORMATION

Last Name	First Name	Initial	Social Security Number (required)

REASON FOR REQUESTED CHANGE

Benefits Change Effective Date: / /

1. Addition of Dependent Coverage — Date of Marriage, Birth, Adoption / /
   - ☐ Spouse ☐ Natural Child
   - ☐ Adopted Child ☐ Stepchild
2. Termination of ALL Dependent Coverage - Reason — Effective Date / /
3. Termination of Named Dependent(s) — Effective Date / /
   - ☐ Spouse ☐ Child(ren)
   - Name(s)
   - Reason(s)
4. Change Plan Option (Open Enrollment Only) — Effective Date / /
   - From: _____ To: _____
5. Change Status — Effective Date / /
   - ☐ Retiree Retiree Age _____
   - ☐ COBRA ☐ Retiree Plan
6. Termination of Life Insurance — Effective Date / /
   - ☐ Basic Life ☐ AD&D ☐ Dependent Life
7. Reinstate Coverage — Effective Date / /
   - ☐ ALL ☐ Employee ☐ Dependent
8. Cancel ALL Coverage — Effective Date / /
   - ☐ Termination of Employment ☐ Leave/Lay Off
9. Other Changes
   - ☐ Name ☐ Address
   - Name
   - Address
   - City Zip Country

EMPLOYEE ELECTION

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family

NETWORK SELECTED

Blue Cross - CA

COVERAGE SELECTED

- ☐ Comprehensive Option
- ☐ Basic
- ☐ SIMNSA (Mexico ONLY)

DEDUCTION (Board Members & Retirees ONLY)

- ☐ One lump sum (due by Aug 30)
- ☐ 2 equal payments (due Aug 31 & Jan 31)
- ☐ 10 Equal payments (due last day of each month Aug - May)

EMPLOYER USE ONLY

Name of EMPLOYER (District): IMPERIAL COMMUNITY COLLEGE DISTRICT / IMPERIAL VALLEY COLLEGE

Employment Date

Employment Status

- ☐ Faculty
- ☐ Classified
- ☐ Confidential
- ☐ Administrator
- ☐ Manager
- ☐ Board Member
- ☐ Retiree

HUB OFFICE USE ONLY

	Initials
Date Received: _____	
Date Processed: _____	
	Initials

EMPLOYEE MUST SIGN HERE

Employee Signature Date

X

E-mail Address:

Use this space to list eligible dependent changes. Last name required if different from employee's

SSN Required for all dependents

Spouse's Name	Date of Birth / /	Sex ☐ M ☐ F	SSN	
Dependent's Name	Date of Birth / /	Sex ☐ M ☐ F	SSN	Relationship ☐ Son ☐ Daughter Other
Dependent's Name	Date of Birth / /	Sex ☐ M ☐ F	SSN	Relationship ☐ Son ☐ Daughter Other