IMPERIAL VALLEY COLLEGE CHANGE OF ADDRESS FORM

EMPLOYEE NAME:	
OLD ADDRESS:	NEW ADDRESS:
Address	Address
City/State/Zip	City/State/Zip
Phone Number	Phone Number
CHANGE IN NAME: NO YES	S – New Name:
Employee Signature	
OFFI	CIAL USE ONLY
Date changed in Human Resources	HR Signature
Date changed in Payroll	Payroll Signature

Medical Benefits - CHANGE / TERMINATION FORM



EMPLOYEE INFORMATION			
Last Name First Name		(Initial)	Social Security Number (required)
REASON FOR REQUESTED CHANGE		EMPLOYEE ELECTION	COVERAGE SELECTED
		☐ Employee Only	
Benefits Change Effective Date:	1	☐ Employee + Spouse	☐ • Comprehensive Option
Addition of Dependent Coverage	Date of Marriage, Birth, Adoption	☐ Employee + Child(ren)	□ * Basic
☐ Spouse ☐ Natural Child		☐ Employee + Family	☐ SIMNSA (Mexico ONLY)
☐ Adopted Child ☐ Stepchild	1	NETWORK SELECTED	
2. Termination of ALL Dependent Coverage - Reason	Effective Date		
	1	Blue Cross - CA	
3. Termination of Named Dependent(s)	Effective Date		
☐ Spouse ☐ Child(ren)		EMPLOYER USE ONLY	
Name(s)	1 1	Name of EMPLOYER (District)	
Reason(s)			
4. Change Plan Option (Open Enrollment Only)	Effective Date	Employment Date	
From: To:	1 1		
5. Change Status	Effective Date	Employment Status	
☐ Retiree Retiree Age	1 1	☐ Full Time	☐ Retiree ☐ COBRA (attach form)
☐ COBRA ☐ Retiree Plan			, ,
6. Termination of Life Insurance	Effective Date	☐ Part Time	☐ Disabled
☐ Basic Life ☐ AD&D ☐ Dependent Life	1	HUB OFFICE USE ONLY	
			Initials
7. Reinstate Coverage	Effective Date		
☐ ALL ☐ Employee ☐ Dependent	1	Date Received:	
8. Cancel ALL Coverage	Effective Date	Date Processed:	
☐ Termination of Employment ☐ Leave/Lay Off	1		Initials
9. Other Changes			
□ Name □ Address			
			<u> </u>
Name		EMPLOYEE MUST SIGN HERE	
		Employee Signature	(Date)
Address		7	
		x	
City Zip	Country	E-mail Address:	
·	·		
Use this space to list eligible dependent changes. Last name required if different froi	n employee's	SSN Required for all d	lependents
Spouse's Name	Date of Birth	Sex SSN	
	1 1	□ M □ F	
Dependent's Name	Date of Birth	Sex SSN	Relationship
	1 1	□ M □ F	☐ Son ☐ Daughter Other
Dependent's Name	Date of Birth	Sex SSN	Relationship
	1 1	□ M □ F	□ Son □ Daughter Other



P.O. Box 942709 Sacramento, CA 94229-2709 Telephone (888) 225-7377 FAX (916) 795-3287 TDD (916) 795-3240

PERS-AESD-1 (02/2002)

(Please PRINT or TYPE clearly)

INCOMPLETE OR IMPROPERLY COMPLETED FORMS MAY BE RETURNED TO YOU

Member Action Request

1 SOCIAL SECURITY NUMBER	2 Current Name (First, Middle	, Last)	3 Daytime Phone Number		
- <u>-</u>			()		
4 Date of Birth 5 Gender	6 Former Name - For name ch	nanges only (First, Middle, La	ast)		
MM DD YYYY					
7 Mailing Address:	8 Remarks	(pertaining to CalPERS)			
In Care of (if applicable):					
Street/P.O. Box:					
Additional Address Line:	9 Employe	r Name			
City:					
State: ZIP Code: -					
10 Effective Date of Action 11 Subject to Section 2	20306 12 Employer Code	13 District Code (Schools			
MM DD YYYY Yes] No 0286	001	MM DD YYYY		
15 Type of Action (check all boxes that apply for this Effective	ve Date; if none apply, indicate a	ction needed in "Remarks" [#	#8] above):		
A. Appointment/Membership E.	Military Leave	I. Alternate	e Retirement Plan (G.C. 20306)		
B. Return from Leave F.	Worker's Comp Leave	J. Name Cl	hange		
C. Separation, Permanent G.	Sabbatical Leave	K. Address	Change		
D. Separation, Temp (≧ 2 months) H.	Maternity/Paternity Leave	L. Coverag	e Group Change		
16 Coverage Group 17 Job/Position Title		18 ½ @	55 Formula		
60004					
		Co	ont. Rate:		
 This person is an Optional Member (e.g., "Election (Please attach appropriate election form AESD-3 		e") who is electing membersh	nip.		
20 BASIS FOR MEMBERSHIP QUALIFICATION: (O	ptional informational field. Ch	eck appropriate box.)			
Full-Time for > 6 months					
Part-Time for ≧ 20 hours for 1 year or more					
Indeterminate; at least 20 hours a week for 1 year or more					
Has completed 1,000 hours or 125 days in fiscal year Person is already a PERS member					
21 Form Completed By:					
(Name & Title)					
(Telephone Number) (Fax Number)	(Date)				
(Signature of Certifying Officer)	(Date)		_		

Address Change Request

AS 0786 (Rev. 4/10)

CALSTRS

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

Instructions

Check one of the following:

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 California and you do not submit a new *Income Tax Withholding Preference Certificate*, CalSTRS will discontinue withholding state tax from your benefit. If you are moving from another state to California and do not submit a new *Income Tax Withholding Preference Certificate*, CalSTRS will withhold state tax from your benefit at the rate for married persons with three exemptions.

☐ Change mailing address for CalSTRS correspondence. I do not receive benefit payments at this time.					
☐ Change mailing address for my benefit payments.	Change mailing address for my benefit payments.				
Change my mailing address to the address listed below and continue sending my benefit payments to my finan institution.	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 <i>Direct Deposit Authorization</i> form if your payment is sent by electronic funds transfer.					
☐ Cancel my <i>Direct Deposit Authorization</i> and send my payments to the address listed below.					
Other (use back of form for additional space):					
NAME (LAST, FIRST, INITIAL) MAILING ADDRESS DATE OF BIRTH (MM/DD/YYYY) () CITY STATE ZIP CODE CUENT ID OR SOCIAL SECURITY NUMBER HOME TELEPHONE	3				
CITY STATE ZIP CODE HOME TELEPHONE					
E-MAIL 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.

