

**IMPERIAL VALLEY COLLEGE
CHANGE OF ADDRESS FORM**

EMPLOYEE NAME: _____ **G#** _____

SSN# XXX-XX - _____

OLD ADDRESS:

NEW ADDRESS:

Address

Address

City/State/Zip

City/State/Zip

Phone Number

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



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 Female Male Unknown		Phone Number	Home Cell Work
Mailing Address: Street/P.O. Box: City: State: ZIP Code:			District Name (Division): Job Position/Title:		
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

D. Separation (select reason)

- Date: _____ Last day worked: _____
- Unused Sick Leave Hours: _____
- Deceased Date: _____
- Layoff Workers Comp Leave
- Permanent Maternity/Paternity Leave
- Military Leave Retirement

B. Name Change

Former Name: _____

C. Address Change

Membership Information:			
	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			CalPERS ID:
Update ICSIS Membership	Update MyCalPERS	User: _____ Date: _____	

Address Change Request

AS 0786 (rev 10/13)

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 *myCalSTRS* 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 *myCalSTRS* 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

Medical Benefits - CHANGE / TERMINATION FORM



EMPLOYEE INFORMATION			
Last Name	First Name	Initial	Social Security Number (required)

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

EMPLOYEE ELECTION	COVERAGE SELECTED
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family	<input type="checkbox"/> Comprehensive Option <input type="checkbox"/> Basic <input type="checkbox"/> SIMNSA (Mexico ONLY)
NETWORK SELECTED	
Blue Cross - CA	

EMPLOYER USE ONLY	
Name of EMPLOYER (District) _____	
Employment Date _____	
Employment Status _____	
HUB OFFICE USE ONLY	
Date Received: _____	Initials
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 <input type="checkbox"/> M <input type="checkbox"/> F	SSN		
Dependent's Name	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	SSN	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter Other	
Dependent's Name	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	SSN	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter Other	