

PATERSON PUBLIC SCHOOLS

Preparing All Children for College and Career



Department of Human Resource Services

90 Delaware Avenue
Paterson, NJ 07503
973-321-0744

Employee: _____
First Name MI Last Name

Today's Date: _____ Social Security: XXX-XX-_____

Position: _____ Location: _____

Emergency Contact: _____ Telephone: _____

TYPE OF CHANGE ACTIVITY

(Please check all applicable boxes)

Name Change:
(Please provide a copy of your Social Security Card) _____
(New Name)

New Address/Phone:
(Please provide proof of Address) _____
(Address)

(City, State, Zip Code)

(Home Telephone with Area Code)

Marriage
(Please provide a copy of your Marriage certificate) _____
Date of Marriage/Civil Union: _____

Former/Maiden Name: _____

***Divorce - Separation - Death**
(Please circle event and see * below) _____
Date of Event: _____

Deleted Person: _____

Please Note Important:

For all changes to your health benefits, i.e., marriage, divorce, death of spouse or child, you must come to the Health Benefits Office to complete a new enrollment application to either remove or add someone to your health benefits coverage. The State Health Benefits Program must receive all applications within 60 days of the date of the event. Address changes for SHBP members must call the Division of Pensions and Benefits- Office of Client Service at (609) 292-7524 and request a change of their SHBP address. For VSP address change please register go to www.vsp.com or call (800)877-7195. For Delta Dental address change please register go to www.deltadentalnj.com For Flagship plan fax to (973)285-4162 or mail to Delta Care Flagship P.o. Box 369, Parsippany, NJ 07054 or E-mail

*** In the case of divorce or death, you must remove the dependent from your health benefits within 30 days of the event. Failure to do so may result in the garnishment of your pay to recover the cost of medical coverage for your ineligible dependent.**

EMPLOYEE SIGNATURE: _____
(Date)

PROCESSED BY: _____
(Date)

****Please submit this form with original signatures to the Department of Human Resource Services.
If you have any questions, please feel free to contact us.***

CC: Health Benefits
Payroll
HR

REVISED: 3/7/14gm



FC-0162-0310

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
PO Box 295, Trenton, NJ 08625-0295

CHANGE OF ADDRESS FORM

Please print all required information and return the completed form to the mailing address shown above. This form will be rejected if your retirement/membership number and/or your Social Security number is not completed.

Date: _____

Name: _____

Pension System: PERS TPAF DCRP PFRS SPRS ABP JRS

Membership or Retirement Number: _____

Social Security Number: _____ - _____ - _____

Daytime Phone Number: (_____) _____
AREA CODE

Type of Change: **Active Employee Address Change for Health Benefits**
Note: This Division does not maintain addresses for active employee pension accounts. Notify your employer of any change in your address.

Retiree Address Change for Pension and Health Benefits

Former Mailing Address: _____
ADDRESS

_____ ADDRESS 2

_____ CITY STATE ZIP

Date New Address in Effect: _____
MONTH DAY YEAR

New Mailing Address: _____
ADDRESS

_____ ADDRESS 2

_____ CITY STATE ZIP

Signature of Member or Retiree

