NAME CHANGE

Please complete the Employee Section and Submit to your department head.

Former Name: _____

New Name: _____

Date of Effective Change: ___/____/_____

EMPLOYEE:

- ☐ Updated I-9 form
- ☐ Updated Life Insurance Beneficiaries *(if applicable)*
- ☐ Insurance: Medical___ Dental___ Vision___ (Please check all that apply)
- ☐ Copy of new identification/ marriage license/social security card

DEPARTMENT HEAD:

- ☐ PSC Form

HUMAN RESOURCES:

- ☐ Update Munis system profile *(Print Proof of Change)*
- ☐ Update all Insurances
- ☐ Dental/Vision *(Print Proof of Change)*
- ☐ MedCost *(Print Proof of Change)*
- ☐ Life Insurances *(If name change is due to marriage, check beneficiaries)*
- ☐ Update personnel file
- ☐ Update County ID Badge