COUNTY OF ERIE
EMPLOYEE UPDATE FORM

EMPLOYEE'S NAME____SSN____________________________________

DEPARTMENT____

FOR PERSONNEL OFFICE USE ONLY
for address change - send copy to:
group benefit & plan #_______________

BARGAINING UNIT:

- ___AFSCME clerical/technical
- ___AFSCME professional
- ___PSSU (Prison)
- ___PSSU (Child. & Youth)
- ___ECAPE (Courts)
- ___Detectives (D.A.)
- ___Non-bargaining
- ___N/A - per diem employee

Check √ appropriate box(es) where **change(s)** occurred and complete applicable information:

❒ **NAME** new name:_______________________________former name: ________________________________

❒ **ADDRESS** new address:____ ☞
(Street) (City) (State) (Zip code)

➘ ***Do you have a savings bond deduction through the County payroll department?*** _____***yes*** _____***no***

❒ **PHONE #** new phone #: (_______) -_________________________

❒ **CHANGE IN MARITAL STATUS** ☞ ❒ marriage ❒ separation ❒ divorce ❒ death of spouse

❒ **ADDITION OF DEPENDENT TO INSURANCE**

❒ spouse

❒ child ☞ ❒ birth ❒ adoption ❒ step child(ren) by marriage ❒ child age 19+ & full-time student*

Name of school attending____ _________________

*NOTE: dependent child is automatically removed at age 19; however they will be eligible for continued health insurance coverage as a full-time student up to age 25 - you must continue to notify Personnel on a yearly basis of continuing student status of child over age 19.

dependent's name____sex_______DOB_________________________

❒ **REMOVAL OF DEPENDENT FROM INSURANCE**

❒ spouse or former spouse ☞ reason: ____________________________________

❒ child ☞ reason:
- ❒ age **19 or over** & no longer a full-time student
- ❒ reached age **25** (previously had coverage as student)
- ❒ marriage
- ❒ other _________________________

(former) dependent's name____DOB_________________________

❒ **EMPLOYEE ELIGIBLE FOR MEDICARE** (age 65 or on disability)

❒ continue County's insurance as primary coverage OR ❒ change to Medicare as primary coverage

date of your 65th birthday______________________________ OR date of disability____________________________

❒ **EMPLOYEE'S SPOUSE ELIGIBLE FOR MEDICARE** (age 65 or on disability)

❒ continue County's insurance as primary coverage OR ❒ change to Medicare as primary coverage

date of spouse's 65th birthday___________________________ OR date of disability____________________________

____ _____________________ ______________________

(signature of employee) (date signed) (effective date of change)

RETURN THIS FORM TO PERSONNEL IMMEDIATELY UPON A CHANGE OCCURRING. Personnel will forward to you the necessary forms to be completed and, upon receipt of those completed forms, will notify other interested parties. However, if you are a Credit Union or Deferred Compensation participant, you must notify them directly of any name, address or other applicable change. PSSU bargaining employees must notify union steward of changes in dependents (for Health & Welfare benefit purposes).

THIS SECTION FOR PERSONNEL DEPT USE ONLY

EMPLOYEE'S NAME____SSN_____________________________

DEPARTMENT____

BARGAINING UNIT___________________

NAME CHANGE (MARITAL STATUS, ETC.)	**FORMS SENT**	**FORMS FILED (PERSONNEL FILE/MEDICAL FILE) (watch for single to dependent or vice versa)**
BAI FORM (Everyone)		
UNION FORM (AC, AP, PO, PS, PC)		
VBA (NB, EC, AO, EL, CS, DE)		
CONTROLLER (Pension)		
COMPUTER (Jury Duty List)		
EMERGENCY CONTACT FORM		
LIFE INSURANCE BENEFICIARY		
PENSION BENEFICIARY (Controller)		
W-4 FORM (Payroll)		
OPERATIONS (Phone List/Badge)		
100 FORM (Civil Service Employees)		

ADDRESS CHANGE	**FORMS SENT**	**FORMS FILED (PERSONNEL FILE/MEDICAL FILE)**
BAI FORM (Everyone)		
UNION FORM (AC, AP, PO, PS, PC)		
VBA (NB, EC, AO, EL, CS, DE)		
CONTROLLER (Pension)		
100 FORM (Civil Service Employees)		
COMPUTER (Jury Duty List)		

ADD/REMOVE DEPENDENT(S)	**FORMS SENT**	**FORMS FILED (PERSONNEL FILE/MEDICAL FILE) (watch for single to dependent or vice versa)**
BAI FORM (Everyone)		
UNION FORM (AC, AP, PO, PS, PC)		
VBA (NB, EC, AO, EL, CS, DE)		

RETIREE/COBRA (Address/Name/Status Change)	**FORMS SENT**	**FORMS FILED (Medical File)**
BAI FORM (Everyone)		
UNION FORM (AC, AP, PO, PS, PC)		
VBA (NB, EC, AO, EL, CS, DE)		
CONTROLLER (Pension)		
COMPUTER (Jury Duty List)		

BAI CHANGE IN ENROLLMENT INFORMATION FORM

☐ **Medical** ☐ **Dental** ☐ **Vision**

Employees Last Name	First Name	Middle Initial	☐ Male ☐ Female	Social Sec. #
Address	City	State	Zip	Date Of Birth

THE FOLLOWING CHANGES ARE REQUESTED

☐ Name Change To: ______________________________

☐ Address Change To: ______________________________

☐ Other Changes: ______________________________

______________________________ Effective Date: ______________

☐ Coverage Change To: ☐ Single ☐ Dependent

☐ **Add New Dependents**

Name(s)	Soc. Sec. #	Relationship	Date Of Birth	Effective Date

☐ **Remove Dependents:**

Name(s)	Soc. Sec. #	Effective Date

______________________ Date

______________________ Signature Of Employee

EMPLOYER'S STATEMENT

Name of Employer Division

____

____
Employer-Authorized Signature and Title

Benefit Administrators, Inc.
1250 Tower Lane • P.O. Box 6279
Erie, PA 16512

150 South 43rd St., Suite 4
Harrisburg, PA 17111-5708
Phone: (800) 692-7332
(717) 564-9338

TRANSACTION FORM

AFSCME Health & Welfare Fund Use Only

Local # ______________ NPA # ______________

Delta # ______________ Effective Date ________________

PLAN

- ☐ Prescription
- ☐ Vision
- ☐ Dental

TRANSACTIONS

☐ Enrollment	☐ Change of address	☐ Other leaves of absence
☐ Reinstatement	☐ Name change	☐ Other - indicate in remarks
☐ Termination	☐ Sick Leave	

Employee Name	Birth Date (M, D, Y)	Social Security Number
Address	Home Telephone #	Work Telephone #
	Marital Status	
City	☐ Male	☐ Female
State Zip Code		
Employer		

DEPENDENT INFORMATION

Name	Month	Day	Year	Sex (M/F)
Spouse				
Child				
Child				
Child				
Child				
Other Relationship				

Please indicate any additional dependents on the back of this form

REMARKS

_______________________ Employee Signature

_______________ Date (M, D, Y)

I request and apply for enrollment (or change) for benefit coverage. I understand that this application is subject to approval by the Fund. Any person or organization that has provided health related services to me or to any of my beneficiaries named on this application is hereby authorized and released to furnish to the Fund any information or records relating to these services. As condition precedent to payment of claims I hereby agree that the Fund shall have all legal rights of subrogation on my behalf and/or the behalf of my beneficiaries for recovery against third parties and or other providers legally obligated to pay such claims. Any additional documents required for release of any such information or record, or subrogation will be promptly signed by me and/or my beneficiary.

DCED-CLGS-06 (1-11)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF COMMUNITY & ECONOMIC DEVELOPMENT
GOVERNOR'S CENTER FOR LOCAL GOVERMENT SERVICES

LOCAL EARNED INCOME TAX RESIDENCY CERTIFICATION FORM

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change.

EMPLOYEE INFORMATION - RESIDENCE LOCATION			
NAME (Last, FIrst, Middle Initial)			SOCIAL SECURITY NUMBER
FIRST LINE OF ADDRESS (If PO Box, please include actual street address)			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough, Township)			
COUNTY	PSD CODE		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION - EMPLOYMENT LOCATION			
EMPLOYER NAME (Use Federal ID Name)			EMPLOYER FEIN
FIRST LINE OF ADDRESS ('If PO Box, please include actual street address)			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	PHONE NUMBER
MUNICIPALITY (City, Borough, Township)			
COUNTY	PSD CODE		MUNICIPAL NON-RESIDENT EIT RATE

CERTIFICATION		
SIGNATURE OF EMPLOYEE	SIGN HERE	DATE
PHONE NUMBER	EMAIL ADDRESS	

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com

Select Get Local Gov Support, >Municipal Statistics