



MOTT COMMUNITY COLLEGE
New Hire & Personal Information Change Form

Name _____ SSN# _____

EVENT: *(Additional forms, if required by the insurance carrier[s], will be forwarded to you upon receipt of this notification.)*

<input type="checkbox"/> New Hire	<input type="checkbox"/> Address Change	<input type="checkbox"/> Emergency Contact Change
<input type="checkbox"/> Name Change <i>(Attach appropriate documentation)</i> Former Name _____		
<input type="checkbox"/> Marriage <i>(Complete "Spouse & Dependent" section below and attach copy of marriage certificate.)</i>		
<input type="checkbox"/> Add Dependent <i>(Complete "Spouse & Dependent" section below and attach copy of birth or adoption certificate.)</i>		
<input type="checkbox"/> Divorce <i>(Attach copy of divorce decree)</i> Former Spouse _____		
<input type="checkbox"/> Death of Spouse/Dependent <i>(Attach copy of death certificate)</i> Deceased Spouse/Dependent _____		

ADDRESS:

Address _____	Telephone _____
City, State, Zip _____	

PERSONAL DATA: *(Required for New Hires Only)*

GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____
ETHNICITY: <i>(Please check only one of the following government-defined categories)</i>	
<input type="checkbox"/> Black	<input type="checkbox"/> White
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian / Pacific Islander
<input type="checkbox"/> American Indian / Alaskan Native	

EMERGENCY CONTACT INFORMATION:

Name _____	Relationship _____
Address _____	
City, State, Zip Code _____	
Telephone _____	

SPOUSE & DEPENDENT INFORMATION:

Spouse _____	DOB _____	SSN _____
Dependent _____	DOB _____	SSN _____ Relation _____
Dependent _____	DOB _____	SSN _____ Relation _____
Dependent _____	DOB _____	SSN _____ Relation _____
Dependent _____	DOB _____	SSN _____ Relation _____
Dependent _____	DOB _____	SSN _____ Relation _____

Employee Signature _____ **Effective Date** _____