



CHANGE OF ADDRESS NOTIFICATION

SOCIAL SECURITY NUMBER:

Your Social Security number is necessary for identification of your TRS account.

NAME: _____
(Please print in black ink or type)

OLD MAILING ADDRESS:

City, State _____ Zip _____

NEW MAILING ADDRESS:

City, State _____ Zip _____

Signature _____
(Required before address will be updated.) Date signed _____

This form is used to make corrections to your mailing address. If you have a name change or a beneficiary change, contact your school business office or TRS for the appropriate form. To correct a Social Security number, send TRS a copy of your Social Security card.



Change/Termination Request

Request For: Change Addition Deletion Termination

Location:

Social Security #:

Employee Name:

Requested Effective Date:

MEDICAL

Add Coverage:

Plan A B

List All Dependents To Be Included For Coverage

First Name	Initial	Last Name	Relationship	Sex	Social Security #	Date of Birth

ARE ANY OF YOUR DEPENDENTS COVERED BY A QUALIFIED MEDICAL CHILD SUPPORT ORDER? Yes No
(IF YES COMPLETE INFORMATION BELOW)

Custodial Parent: Name of Dependent:	<input type="text"/>	Custodial Parent: Name of Dependent:	<input type="text"/>
Residential Address:	<input type="text"/>	Residential Address:	<input type="text"/>

Are you or any of your covered dependents covered by any other Medical Insurance?
 Yes No

If Yes:

Policy or Group #	Name of Insurance	Who is covered under this Plan?

Delete Coverage:

List All Dependents That Should Be Excluded From For Coverage

First Name	Initial	Last Name	Relationship	Sex	Social Security #	Date of Birth

Address Change: Address: City: State: Zip:

Birthdate: Name Change:
 Covered Class: Social Security #:
 Phone #: Work Home Other Insurance:

Reason For Change/Termination:

- Marriage Divorce Birth Adoption Transfer Termination of Employment Death Layoff
 Dependent Child Over Age Limit Cobra Transfer Changed Health Coverage QMCSO Other _____

Employee's Signature _____

Date _____

Employer's Signature _____

Date _____

To be completed by TPA:

Date Entered/Initials _____

Dated Ordered ID Card _____

PERSONNEL DIRECTORY INFORMATION
TYLER INDEPENDENT SCHOOL DISTRICT
SCHOOL YEAR 2000-2001

NAME Mr. _____
Mrs. _____
Ms. _____, _____, _____
Miss _____ Last(Print) First(Print) MI
Dr. _____

Tyler Independent School District employees may choose to open (listed) or close (unlisted) access to their telephone number and address. Unlisted numbers and addresses will not be included in the TISD directory, but may be given to administrators or your supervisor. Please indicate your wishes.

ADDRESS _____
Street or Route, Box Number

City State Zip
ADDRESS *Listed* _____ *Unlisted* _____

TELEPHONE _____
TELEPHONE *Listed* _____ *Unlisted* _____

SCHOOL CAMPUS _____

ASSIGNMENT _____
Grade and/or All Subject Areas -- Be Specific

Social Security # _____

If the information above is a change, please check the appropriate blank below.

NAME CHANGE _____ **FORMER NAME** _____

ADDRESS CHANGE _____

TELEPHONE CHANGE _____

SIGNATURE _____ **DATE** _____