

ADDRESS, NAME AND BENEFICIARY CHANGE FORM

Employee Information (Please Print)	
Company <i>The College of St. Scholastica</i>	Location Division (If applicable)
Employee Name	Social Security Number
Date of change effective:	

Old Address		
Home Address		Phone
City	State	Zip Code

New Address		
Home Address		Phone
City	State	Zip Code

Name Change	
Change from:	
Change to:	

Change Life Insurance Beneficiary to:	
Primary	Relationship
Secondary	Relationship
<i>If Beneficiary is not related to you, please provide Date of Birth, Social Security Number and full address. Give FULL names and relationships of each beneficiary</i>	

Signature	Date