

READING SCHOOL DISTRICT

Human Resources

Change of Information Form

EMPLOYEE NAME (please print)
(Previous name if applicable)

SOCIAL SECURITY #

**PLEASE FILL IN WHERE YOUR INFORMATION HAS CHANGED AND FORWARD TO HUMAN RESOURCES
WITH REQUIRED DOCUMENTS (if needed) AFTER COMPLETION.**

NEW ADDRESS:

STREET

APT #

CITY, STATE, ZIP

RESIDENT MUNICIPALITY (CITY-BOROUGH-TOWNSHIP)

COUNTY

NEW PHONE NUMBER:

CELL PHONE NUMBER:

NEW NAME:

BE SURE TO ATTACH A COPY OF YOUR MARRIAGE CERTIFICATE/DIVORCE DECREE AND NEW SOCIAL SECURITY CARD. ALSO ATTACH A NEW W-4, NEW I-9 AND NEW EIT FORM (obtainable in the HR office). **THE NAME CHANGE CANNOT BE MADE WITHOUT THESE DOCUMENTS.**

EMPLOYEE SIGNATURE:

DATE:

PLEASE NOTE: This Change of Information Form will **NOT** change your beneficiary of insurance coverage. If your change of status results in a change of beneficiary or change of insurance coverage, you must notify the Payroll Department (484-258-7072) and the Insurance Department (484-258-7025) as soon as possible after the change occurs. If you have any questions, please feel free to contact the HR department (484-258-7010).

THIS SECTION IS FOR OFFICE USE ONLY

Person making change in records, please sign off:

H.R. Accounts Payable Insurance Act 48 MIS

CC: Personnel File

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