

MOTT COMMUNITY COLLEGE

New Hire & Personal Information Change Form



EMPLOYEE NAME: _____ SSN: _____

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

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

CONTACT INFORMATION

Street Address _____

City, State, Zip _____ Telephone _____

PERSONAL DATA *(Required for New Hires Only)*

Gender: Male Female Date of Birth _____

Ethnicity:

Are you Hispanic or Latino? *(Persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.)* Yes No

Select one or more of the following races:

- American Indian or Alaskan Native:** *Persons having origins in any of the original peoples of North and South America (including Central America), and who maintain cultural identification through tribal affiliation or community recognition.*
- Asian:** *Persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.*
- Black or African American:** *Persons having origins in any of the Black racial groups in Africa.*
- Native Hawaiian or Other Pacific Islander:** *Persons having origins in any of the peoples of Hawaii, Guam, Samoa or other Pacific Islands.*
- White:** *Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.*

EMERGENCY CONTACT

Name _____ Relationship _____

Street Address _____

City, State, Zip _____ Telephone _____

SPOUSE & DEPENDENT INFORMATION *(Only required if you are enrolling in benefits)*

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: _____ DATE: _____