



HR Change of Name Form

Current Name: _____ J Number: _____

Effective Date: _____ Last 4 of SSN: _____

New Name: _____

Phone Number: () _____ - _____

In order to update your name on file, you must submit a copy of your social security card; verifying the name change. According to our records, you have selected the following coverage(s). HR will provide this form to the respective benefits vendors to request the change be made as of the above effective date.

- State of Mississippi Health and Life (BlueCross BlueShield of MS)
- Southern Administrators & Benefit Consultants (Cafeteria Plan & Flexible Spending Accounts)
- Superior Vision
- Delta Dental
- Cigna Long Term Disability

Employee Signature

Date

For Employer Use Only

HRIS Representative Signature

Date

HR Benefits Signature

Date