

Office of Human Resources

Name Change Packet

This form must be completed when a benefit-eligible staff or faculty member changes address, marital status, and/or benefit plan enrollment. These forms must be processed and returned to the Human Resources office within 30 days of the qualifying event and/or status change.

✓ **Qualifying Events:** A change in your situation — like getting married, having a baby, or losing health

coverage (this form is required outside the Open Enrollment Period).

✓ **Verifying Dependents:** When enrolling a spouse or child for changing a spouse or child's enrollment in

required

the request for name change.

Forms to be returned for a name change:

Office of Human Resources Data Change Form

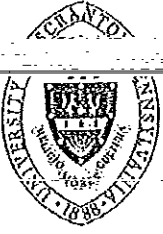
W-4 (only if you wish to change your federal withholding)

Residency Certification

Retirement Vendor Information Change Form

* Only complete the form for the vendor you have an account with

All forms are available in the Office of Human Resources, St. Thomas Hall room 100



Data Change Form

Please print all information in Ink.

Name: _____

R# _____

Effective Date of Change: _____

Check the appropriate box(es) to indicate a change to your personal information as indicated below:

Name: _____
(Please provide supporting documentation i.e. marriage certificate, divorce decree, etc.)

Physical Address: _____ If different, provide Mailing: _____

Telephone Number: _____ Home Cell

Marital Status: Please provide supporting documentation i.e. marriage certificate, divorce decree, etc.

Add Remove the following spouse/dependent(s):
(Please provide supporting documentation i.e. birth certificate, marriage license, divorce decree, etc.)

NAME		Birth
	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Male <input type="checkbox"/> Female
	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Male <input type="checkbox"/> Female
	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Male <input type="checkbox"/> Female

Check emergency contact person: (if applicable)

(Name)

(Address)

(City, State, Zip)

(Phone Number)

(Signature)

(Date)

Highmark _____
JICCI _____
COBRA _____

Received in HR _____
Date Completed _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.

Give Form W-4 to your employer.

Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1:

(a) First

Enter
Personal
Information

-
-
-

Employee's signature (This form is not valid unless you sign it.)

Date

**Employers
Only**

Employer's name and address

General Instructions

Section



RESIDENCY CERTIFICATION FORM

Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers to report to the tax collector the essential information for the collection and distribution of Local Earned Income Taxes of a name and/or address change or other information that may affect the tax collector contact information.

NAME (Last Name, First Name, Middle Initial)		SOCIAL SECURITY NUMBER	
STREET ADDRESS (No PO Box, RD or RR)			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	HOME NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	RESIDENT ID CODE	EMPLOYER ID CODE	TOTAL RESIDENT FIT RATE

EMPLOYER BUSINESS NAME (Use Federal ID Name)	EMPLOYER ID		
University of Scranton	240708495		
STREET ADDRESS (No PO Box, RD or RR)			
900 Linden St			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	HOME NUMBER
Scranton	PA	18510	070-841707
MUNICIPALITY (City, Borough or Township)			
Scranton			
Lackawanna			

CERTIFICATION

SIGNATURE OF EMPLOYEE	PHONE NUMBER

please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com/Act32

THE UNIVERSITY OF
SCRANTON
A JESUIT UNIVERSITY

HUMAN RESOURCES

TO: TIAA-CREF
FROM: UNIVERSITY OF SCRANTON
OFFICE OF HUMAN RESOURCES
RE: REQUEST FOR ADDRESS CHANGE
FAX: (800) 914-8922

Please update address for any and all accounts held by the participant listed below.

Participant Name: _____ Effective Date of Change: _____

Social Security Number: _____

Previous Address

New Address

Signature of Accountholder

Date

Signature of HR Representative

Date