



**EMPLOYEE CHANGE FORM**

Name of Employee: \_\_\_\_\_ Date of Change: \_\_\_\_\_

Current Account(s): \_\_\_\_\_

New Address: \_\_\_\_\_  
Street \_\_\_\_\_  
City, State Zip Phone Number \_\_\_\_\_

Marital Status Change  Married  Single

Social Security Card Name Change From: \_\_\_\_\_ To: \_\_\_\_\_

**Position Information**

Position Change  
New Title: \_\_\_\_\_  
Previous Title: \_\_\_\_\_  
Reason: \_\_\_\_\_

**\*Please attach a new job description outlining at least three critical functions of the new position.\***

Appointment end date: \_\_\_\_\_ Revised appointment end date: \_\_\_\_\_

Separation – Last day worked: \_\_\_\_\_

Reason for separation: \_\_\_\_\_

SIBCR Account Change  
Previous SIBCR Account(s): \_\_\_\_\_ New SIBCR Account(s): \_\_\_\_\_

Pay Rate Change  
Previous Rate: \_\_\_\_\_/  Hour  Month New Rate: \_\_\_\_\_/  Hour  Month  
Justify salary increase (or attach justification): \_\_\_\_\_

Change of Approx. Hours/Week: \_\_\_\_\_ or Percent Effort: \_\_\_\_\_

**Benefits**

Check benefits for which employee is now eligible:  
 Annual and Sick Leave (15 consistent hours per week with an expected appointment of  $\geq$  12 months)  
 Medical, Dental and Vision Insurance (50% effort with an appointment of 1 year or more)  
 TIAA CREF Retirement Savings Plan (More than 1,000 hours in 1 year or less of service)  
 Life and Short & Long Term Disability (30hrs/wk for 1 year or more)  
 None

**Please sign below:**

\_\_\_\_\_  
Employee Date

\_\_\_\_\_  
Supervisor Date

\_\_\_\_\_  
Personnel Date