CITY OF MARQUETTE
CHANGE OF PERSONAL INFORMATION

Name: _____ Employee Number: _____

Department: _____

I wish to change (please check all that apply):

- ☐ Name
- ☐ Address
- ☐ Phone Number
- ☐ Marital Status
- ☐ Health Insurance*
- ☐ Life Insurance*
- ☐ Pension*

Effective date of change: _____

	FROM	TO
1.		
2.		
3.		
4.		

*To make additions/deletions on your group health insurance coverage, life insurance, and pension, please complete the appropriate forms in the Human Resources Department.

Please complete this form and return it to the Human Resources Department.

_____ _____

Employee Signature Date

Print Form