PATERSON PUBLIC SCHOOLS

Preparing All Children for College and Career
Together We Can

Department of Human Resources
90 Delaware Avenue
Paterson, NJ 07503
973-321-0744

Demographic Change Form

Employee: _____ Today's Date: _____
First *MI* *Last*

Social Security: XXX-XX-_____ Position: _____ Location: _____

Emergency Contact: _____ Emergency Contact Telephone: _____

TYPE OF CHANGE ACTIVITY:

(Please check all applicable boxes)

☐ **Name Change:**
(Please provide a copy of your social security card) Must also complete W-4 Forms with New Name Change.

_____
(New Name)

☐ **New Address/Phone:**
(Please provide proof of address)
***Proof of address includes one of the following:**

- License
- Lease
- Utility Bill

_____
(Address)

_____
(City, State, Zip Code)

_____
(Home Telephone with Area Code)

☐ **Marriage**
(Please provide a copy of your marriage certificate)

Date of Marriage/Civil Union: _____

Former/Maiden Name: _____

☐ **Divorce**
(Please provide a copy of your divorce papers and see *

Date of Event: _____

Deleted Person: _____

Please Note Important

*For all changes to your health benefits, i.e. marriage, divorce, death of spouse or child, you must come to the Health Benefits Office to complete a new enrollment application to either remove or add someone to your health benefits coverage. Paterson Public Schools must receive all applications within **30** days of the date of the event. For VSP address change please register, go to www.vsp.com or call (800) 877-7195. For Delta Dental address change please register, go to www.deltadentalnj.com. For Flagship plan fax (973)285-4162 or mail to: Delta Care Flagship P.O. Box 369, Parsippany, NJ 07054.*

In the case of divorce or death, you must remove the dependent from your health benefits within 30 days of the event. Failure to do so may result in the garnishment of your pay to recover the cost of the medical coverage for your ineligible dependent.

Signature: _____ Date: _____

Processed By: _____ Date: _____

Please submit this form with original signatures to the Department of Human Resource Services. If you have any questions, please feel free to contact us.

CC: Health Benefits
Payroll
HR

Revised: 9/16/2024

FC-0162-0310

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY

DIVISION OF PENSIONS AND BENEFITS
PO Box 295, Trenton, NJ 08625-0295

CHANGE OF ADDRESS FORM

Please print all required information and return the completed form to the mailing address shown above. This form will be rejected if your retirement/membership number and/or your Social Security number is not completed.

Date: _____

Name: _____

Pension System: ☐ PERS ☐ TPAF ☐ DCRP ☐ PFRS ☐ SPRS ☐ ABP ☐ JRS

Membership or Retirement Number: _____

Social Security Number: _____ — _____ — _____

Daytime Phone Number: (_____) _____
AREA CODE

Type of Change: ☐ Active Employee Address Change for Health Benefits
Note: The Division does not maintain addresses for active employee pension accounts. Notify your employer of any change in your address.

☐ Retiree Address Change for Pension and Health Benefits

Former Mailing Address: _____
ADDRESS

_____
ADDRESS 2

_____
CITY STATE ZIP

Date New Address in Effect: _____
MONTH DAY YEAR

New Mailing Address: _____
ADDRESS

_____
ADDRESS 2

_____
CITY STATE ZIP

_____
Signature of Member or Retiree