

THIS SECTION FOR PERSONNEL DEPT USE ONLY

EMPLOYEE'S NAME _____ SSN _____

DEPARTMENT _____

BARGAINING UNIT _____

NAME CHANGE (MARITAL STATUS, ETC.)	FORMS SENT	FORMS FILED (PERSONNEL FILE/MEDICAL FILE) (watch for single to dependent or vice versa)
BAI FORM (Everyone)		
UNION FORM (AC, AP, PO, PS, PC)		
VBA (NB, EC, AO, EL, CS, DE)		
CONTROLLER (Pension)		
COMPUTER (Jury Duty List)		
EMERGENCY CONTACT FORM		
LIFE INSURANCE BENEFICIARY		
PENSION BENEFICIARY (Controller)		
W-4 FORM (Payroll)		
OPERATIONS (Phone List/Badge)		
100 FORM (Civil Service Employees)		

ADDRESS CHANGE	FORMS SENT	FORMS FILED (PERSONNEL FILE/MEDICAL FILE)
BAI FORM (Everyone)		
UNION FORM (AC, AP, PO, PS, PC)		
VBA (NB, EC, AO, EL, CS, DE)		
CONTROLLER (Pension)		
100 FORM (Civil Service Employees)		
COMPUTER (Jury Duty List)		

ADD/REMOVE DEPENDENT(S)	FORMS SENT	FORMS FILED (PERSONNEL FILE/MEDICAL FILE) (watch for single to dependent or vice versa)
BAI FORM (Everyone)		
UNION FORM (AC, AP, PO, PS, PC)		
VBA (NB, EC, AO, EL, CS, DE)		

RETIREE/COBRA (Address/Name/Status Change)	FORMS SENT	FORMS FILED (Medical File)
BAI FORM (Everyone)		
UNION FORM (AC, AP, PO, PS, PC)		
VBA (NB, EC, AO, EL, CS, DE)		
CONTROLLER (Pension)		
COMPUTER (Jury Duty List)		

BAI CHANGE IN ENROLLMENT INFORMATION FORM

Medical

Dental

Employees Last Name 	First Name	Middle Initial	<input type="checkbox"/> Male	Social Sec. #
			<input type="checkbox"/> Female	
Address 	City	State	Zip	Date Of Birth

THE FOLLOWING CHANGES ARE REQUESTED

- Name Change To:  _____ 
- Address Change To:  _____   
- Other Changes: _____
- Effective Date: _____
- Coverage Change To: Single Dependent

Add New Dependents

Name(s)	Soc. Sec. #	Relationship	Date Of Birth	Effective Date

Remove Dependents:

Name(s)	Soc. Sec. #	Effective Date

_____ Date

_____ Signature Of Employee

EMPLOYER'S STATEMENT

Name of Employer

Division

Employer-Authorized Signature and Title



150 S. 43rd Street
 Harrisburg, PA 17111-5708
 Phone: (800) 692-7332
 (717) 564-9338
 Fax: (717) 564-9709

TRANSACTION FORM

Employer ID

Employee Name	Social Security #	Birth Date (M/D/Y)
Address	Home Telephone #	Work Telephone #
Marital Status		
City	State	Zip
	Male	Female
	<input type="checkbox"/>	<input type="checkbox"/>

DEPENDENT INFORMATION

Name	Birth Date	Sex (M/F)
Spouse		
Child		
Other relationship		

Please indicate any additional dependents on the back of this form

TRANSACTIONS

- Enrollment
- Reinstatement
- Termination
- Change of Address
- Name Change
- Medical Leave (for own personal medical condition)
- Other Leaves of Absence
- Other - indicate in REMARKS

Name of Employer	Name of Employer Contact
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REMARKS

Employee Signature

Date

I request and apply for enrollment (or change) for benefit coverage. I understand that this application is subject to approval by the Fund. I certify that the information entered on this form is true and complete. I hereby authorize any person or organization that has provided health related services to me or to any of my beneficiaries named on this application to release and furnish to the Fund any information or records relating to these services. As condition precedent to payment of claims I hereby agree that the Fund shall have all legal rights of subrogation on my behalf and/or the behalf of my beneficiaries for recovery against third parties and or other providers legally obligated to pay such claims. Any additional documents required for release of any such information or record, or subrogation will be promptly signed by me or my beneficiary.



LOCAL EARNED INCOME TAX RESIDENCY CERTIFICATION FORM

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change.

EMPLOYEE INFORMATION - RESIDENCE LOCATION				
NAME (Last, First, Middle Initial)			SOCIAL SECURITY NUMBER	
FIRST LINE OF ADDRESS (If PO Box, please include actual street address)				
SECOND LINE OF ADDRESS				
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER	
MUNICIPALITY (City, Borough, Township)				
COUNTY	PSD CODE		TOTAL RESIDENT EIT RATE	
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

EMPLOYER INFORMATION - EMPLOYMENT LOCATION				
EMPLOYER NAME (Use Federal ID Name)			EMPLOYER FEIN	
FIRST LINE OF ADDRESS (If PO Box, please include actual street address)				
SECOND LINE OF ADDRESS				
CITY	STATE	ZIP CODE	PHONE NUMBER	
MUNICIPALITY (City, Borough, Township)				
COUNTY	PSD CODE		MUNICIPAL NON-RESIDENT EIT RATE	
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

CERTIFICATION			
SIGNATURE OF EMPLOYEE		<div style="background-color: red; color: white; padding: 5px; display: inline-block; border-radius: 10px;"> SIGN HERE </div>	DATE
PHONE NUMBER	EMAIL ADDRESS		

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com
 Select Get Local Gov Support, >Municipal Statistics