

**CHANGE OF NAME, ADDRESS OR PHONE NUMBER**  
**DEACONESS HEALTH SYSTEM**  
 Evansville, Indiana 47747

**PLEASE PRINT**

I.D. NO \_\_\_\_\_ DEPARTMENT \_\_\_\_\_ EFFECTIVE \_\_\_\_\_

NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

FORMER NAME (if changing) \_\_\_\_\_ NEW PHONE \_\_\_\_\_

REASON FOR NAME CHANGE: Marriage \_\_\_\_ Divorce \_\_\_\_; Copy of legal document must be provided to HR – Benefits.

NEW ADDRESS: STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

<b>Do you have Deaconess Medical Insurance?</b>	<b>Yes</b>	<b>No</b>	<b>Are you in the Step-Up Program?</b>	<b>Yes</b>	<b>No</b>
<b>Do you have Deaconess Dental Insurance?</b>	<b>Yes</b>	<b>No</b>	<b>Do you receive Tuition Reimbursement?</b>	<b>Yes</b>	<b>No</b>
<b>Do you have a Savings Bond deduction?</b>	<b>Yes</b>	<b>No</b>	<b>Are you a Quarter Century Club Member?</b>	<b>Yes</b>	<b>No</b>

**Reminder: Please notify the Deaconess Employee Federal Credit Union if you have an account with them.**

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_