

**PERSONNEL CABINET
GROUP LIFE INSURANCE ADMINISTRATION**

EMPLOYEE CHANGE REQUEST

(THIS FORM CAN ONLY BE USED FOR NAME CHANGE, ADDRESS CHANGE OR TERMINATION OF EMPLOYMENT)

SOCIAL SECURITY NUMBER: _____

EMPLOYEE NAME: _____

STREET ADDRESS: _____

CITY: _____

STATE: _____

ZIP CODE: _____

DATE OF BIRTH: _____

GENDER: _____

COUNTY: _____

LOCATION: _____
(location number) (location name)

EMPLOYMENT HIRE DATE: _____
(Enrollment must be sent to Personnel for new hires or plan changes)

EMPLOYMENT TERMINATION DATE: _____

COMPLETED BY: _____ DATE: _____

**Please return completed form to: Personnel Cabinet
Group Life Insurance Administration
501 High Street, State Office Building, 2nd Floor
Frankfort, Kentucky 40601**