SAU #39, P.O. Box 849, 1 School Street, Amherst, NH 03031 603-673-2690

Employee Name and/or Address Change Form checklist

Employee's Name: ______________________________

School District: (circle) Amherst / Mont Vernon / Souhegan / SAU

Effective Date of Change: ____________

Forms to be completed by employee:

____ Employee Name and/or Address Change Form (name change requires legal documentation – social security card, marriage license)
____ Department of Education – Bureau of Credentialing
____ New Hampshire Retirement System
____ NH Local Government Center (benefits) (name change requires new application)
____ W-4 (if recently married or divorced) this year's W-4 can be found on SAU#39 website.
____ Beneficiary change forms (New Hampshire Retirement or Life Insurance)
__X__ Make sure you notify your 403(b)/457(b) agent

Please return forms to Pat Walz, HR Benefits Specialist, 673-2690 ext 110.

For office use ONLY:

- ☐ BudgeSense & AESOP
- ☐ Department of Education: (f) 271-1953
- ☐ NHRS: (f) 410-3501
- ☐ NHLGC: (f) 226-2322
- ☐ AP
- ☐ School

Date completed: ____________ Initials: ________

SAU #39, P.O. Box 849, 1 School Street, Amherst, NH 03031 603-673-2690

Employee Name and/or Address Change Form

I am changing my: ________ name
(former name is: ________________)
________ address
________ telephone number
________ emergency contact person's information

Name: ______________________________

New Address: ______________________________

____

New Phone Number: ______________________________

Emergency Contact Person: ______________________

Phone Number: ______________________

Cell phone: ______________________

Date of Change: ____________

Employee's Signature: ________________________________

Building / School: ________________________________

Virginia M. Barry, Ph.D.
Commissioner of Education
Tel. 603-271-3144

Deputy Commissioner
Tel. 603-271-7301

STATE OF NEW HAMPSHIRE
DEPARTMENT OF EDUCATION
101 Pleasant Street
Concord, N.H. 03301
FAX 603-271-1953
Citizens Services Line 1-800-339-9900

Contact:
Bureau of Credentialing
101 Pleasant Street
Concord, NH 03301
Tel: 271-2409

Name / Address Change Form

Date: ______________________________

Social Security Number: ____________________ OR Teacher #: __________________

I have changed my: ________ Name
(check appropriate box)

former name on file is: ______________________________________
(please PRINT)

________ Address
________ Telephone number

New Name: ________________________________

New Address: ________________________________
(Mailing Address)
____
City State Zip code
____

New Telephone number: ( ) ________________________
Alternative Telephone: ( )

If you would like a reprint of your credential reflecting the changes, please include a check for $20.00 made out to the State of New Hampshire – Treasury.

Email address: ______________________________________

Printed Name: ______________________________________

Signature: ______________________________________ Date Submitted: ______________

New Hampshire Retirement System
54 Regional Drive, Concord, NH 03301
Phone: (603) 410-3500 - Fax: (603) 410-3501
Website: www.nhrs.org - Email: info@nhrs.org

CHANGE OF ADDRESS/NAME

Please Complete the Applicable Areas:

SECTION I – CHANGE OF ADDRESS	
Name (if retired, as it appears on check or non-negotiable)	Social Security Number (last four digits)
Are you currently receiving an NHRS monthly benefit? ☐ Yes ☐ No	Employer's Name (if you are currently employed)
Old Address	New Address
City, State, Zip	City, State, Zip
Old Telephone	New Telephone

SECTION II – CHANGE OF NAME	
Please provide proof of name change (marriage certificate, legal document, etc.)	
Former Name	
Current Name	Effective Date

SECTION III – SIGNATURE	
Please provide your signature to authorize the requested change.	
Printed Name	
Signature	Date

SECTION IV – FOR OFFICE USE ONLY	
ANNUITANT	**ACTIVE**
Retirement #	By
Employer #	Date
By	
Date	

The New Hampshire Retirement System (NHRS) is governed by New Hampshire RSA 100-A, rules, regulations, and Federal laws including the Internal Revenue Code. NHRS also implements policies adopted by the Board of Trustees. These laws, rules, regulations, and policies are subject to change. Even though the goal of NHRS is to provide information that is current, correct, and complete, NHRS does not make any representation or warranty as to the current applicability, accuracy, or completeness of any information provided. The information herein is intended to provide general information only, and should not be construed as a legal opinion or as legal advice. Members are encouraged to address specific questions regarding NHRS with an NHRS representative. In the event of any conflict between the information herein and the laws, rules, and regulations which govern NHRS, the laws, rules, and regulations shall prevail.

NEW HAMPSHIRE
Local Government Center

New Hampshire Municipal Association
Workers' Compensation Trust
Property-Liability Trust
HealthTrust

ADDRESS UPDATE/CORRECTION FORM

DATE: ______________________

SUBSCRIBER INFORMATION *(Please print)*

NAME: ______________________ DATE OF BIRTH: ______________

NEW ADDRESS: ______________________

CITY: ______________ STATE: ______ ZIP: ______________

NEW PHONE: ______________________

GROUP INFORMATION *(Please print)*

BENEFITS ADMINISTRATOR: Patricia J. Walz

GROUP NAME: SAU #39

GROUP PHONE NUMBER: 603-673-2690 ex. 2110

Because all correspondence to New Hampshire
Local Government Center members is based on the information
we have on file, it is important that we maintain correct mailing addresses.

BENEFICIARY DESIGNATION CHANGE REQUEST

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the ING family of companies
("the Company")
PO Box 20, Minneapolis, MN 55440

ING
Your future. Made easier.®

See page 2 for form completion instructions.

INSURED INFORMATION

I am requesting a change in the Beneficiary Designation for: ☒ **Basic Life** ☐ **Supplemental Life** ☐ **Basic and Supplemental Life**

Insured Name ______________________ Birth Date ______________ SSN ______________

Employer/Association Name ______________________ Policy Number ______________

BENEFICIARY INFORMATION

I request that the beneficiaries under this policy/certificate be changed as indicated below. Unless otherwise provided in this request, if two or more primary beneficiaries are named, the proceeds shall be paid in equal shares to the named primary beneficiaries if surviving the insured. If no primary beneficiaries survive, the proceeds shall be paid in equal shares to the named contingent beneficiaries, if any. If no beneficiary survives, payment shall be made according to the terms of the policy. The right of the owner to change the beneficiary hereafter is reserved.

Primary Beneficiary: The person designated to receive insurance proceeds when they become due.

Contingent Beneficiary: An alternate beneficiary designated to receive insurance proceeds if there is no primary beneficiary living at the date of the insured's death. (Also referred to as a secondary beneficiary.)

For each Beneficiary give Full Name, Address (street, city, state and zip code), Birth Date, Social Security Number and Relationship to Insured.

FOR BASIC LIFE INSURANCE

Full Name (First, MI, Last) & Address	DOB	Gender	SSN/TIN	Relationship	%	Beneficiary Type
						☐ Primary ☐ Contingent
						☐ Primary ☐ Contingent
						☐ Primary ☐ Contingent
						☐ Primary ☐ Contingent

FOR SUPPLEMENTAL LIFE INSURANCE

Full Name (First, MI, Last) & Address	DOB	Gender	SSN/TIN	Relationship	%	Beneficiary Type
						☐ Primary ☐ Contingent
						☐ Primary ☐ Contingent
						☐ Primary ☐ Contingent
						☐ Primary ☐ Contingent

AUTHORIZATION AND ACKNOWLEDGMENT

This designation is revocable as to each beneficiary except when otherwise stated, and beneficiaries of like class shall share equally with right of survivorship. Please refer to the Suggested Beneficiary Designations on page 2 of this form. Any designation of an individual shall mean an individual living at the insured's death.

Dated this ______________ day of ______________, 20 ______, at ______________, ______

Owner/Insured Signature ______________________ Date ______________

Irrevocable Beneficiary(ies) Signature(s) *(if any)* ______________________ Date ______________