This form must be received by Human Resources prior to the end of the pay period in which the change is to take effect. Fax completed form to: 1-773-326-1660

CO-EMPLOYEE CHANGES

Service Center Number: _____
Effective Date of Change: _____ (first day of pay period in which change is to take effect)

Co-employee Last Name: _____ **First Name:** _____

COMPLETE ONLY THE INFORMATION THAT HAS CHANGED

☐ **Name Change:** **From:** _____ **To:** _____

☐ **Status Change:** Full-time to Part-time Part-time to Full-time

Reason: _____

☐ **Transfer:** **From:** _____ **To:** _____

☐ **Pay Rate Change:** **New Pay Rate: $** _____ **Per:** Hour ☐ Pay Period ☐ Year ☐

Job Title: _____

Reason: _____

☐ **Address Change:** **New Address:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **County:** _____

☐ **Employment Termination:** **Last Day Worked:** _____ **Type:** Voluntary ☐ Involuntary ☐

Reason: _____

Notice Given? Yes ☐ No ☐ **Eligible for Rehire?** Yes ☐ No ☐

If no, why? _____

Authorized By:

Name: _____ **Date:** _____

Signature: _____

Employee Signature: _____

FOR INTERNAL USE ONLY

Resource ID: _____ **Benefit End Date:** _____ ☐ **LTD/STD** ☐ **Notified Benefit Providers**
- Dental
- Medical