



CITY OF STAFFORD

2610 SOUTH MAIN
STAFFORD, TEXAS 77477
281-261-3900
FAX 281-261-3994

CHANGE OF ADDRESS

Complete this form and return to Darla Steubing, Human Resources

Change address from (Old Address):

City, State, ZIP:

Change address to (New Address):

City, State, ZIP:

Telephone: () _____

Print Name: _____

Signature: _____

Effective Date: _____



TMRS Address or Name Change Form

Please use only black ink and do not highlight. Any corrections or whiteouts must be initialed.

TMRS members and retirees (or other persons receiving a TMRS monthly benefit) may use this form to make Address or Name changes to their TMRS account. After you have completed and signed this form, please fax to (512) 476-5576 or mail to P.O. Box 149153, Austin TX 78714-9153. If you fax the form, please retain the original for your records. If you have any questions regarding this form or any other matter, please call (800) 924-8677.

Please complete this section:

Full Name (first, middle, last)		Social Security Number
Date of Birth	Current or Last Employing City	Daytime Phone Number

Complete this section only if you are changing your mailing address.

My New Mailing Address is:

New Mailing Address (number and street)

City State Zip Code

Daytime Phone Number Evening Phone Number

E-mail Address

Complete this section only if you are changing your name.

This section should only be completed if your name has changed and does not match the name currently on record with TMRS.

Old Full Name (first, middle, last)

New Full Name (first, middle, last)

Reason for Change: marriage divorce court order

NOTE: If you are completing this section, a photocopy of one of the following documents is required with this form: Marriage Certificate, Divorce Decree (Name Change Section), or Court Order.

REQUIRED

Please sign and date this section:

I hereby affirm that the information on this form is true and correct and authorize the Texas Municipal Retirement System to update my TMRS account with this information.

Your Signature _____ Date signed _____



**METLIFE SMALL MARKET
CHANGE REQUEST**

GROUP NAME: _____ GROUP NUMBER: _____

TYPE OF ELIGIBILITY CHANGE: (Please list below)

1. Name Change
2. Address Change
3. Cancel Spouse
4. Cancel 1 Child
5. Cancel All Children
6. Partial Cancellation - (List Coverages to be Cancelled)
7. Cancel All Coverage - Termination of Employment
8. Cancel All Contributory Coverage - Request of Active Employee
9. Change Insurance Amount due to Salary Change

10. COBRA Enrollment (Attach Election Form)
11. COBRA Termination
12. Other _____

QUALIFYING EVENTS: _____ DATE: _____

- Q1. Add Dependent - Marriage
- Q2. Add Dependent(s) - Birth or Adoption
- Q3. Add Dependent(s) - Loss of Coverage*
- Q4. Death
- Q5. Rehired Employee
- Q6. Divorce

All necessary information must be included to avoid processing delays.

COMPLETE FOR ELIGIBLE EMPLOYEE(S)

ELIGIBILITY OR QUALIFYING EVENT CHANGE	LAST NAME	FIRST NAME	Social Security Number	BIRTHDAY MO/DAY/YR	SEX	LIST NEW CHANGE (SALARY/ADDRESS, ETC.)	COVERAGES AFFECTED
# EFFECTIVE DATE							

COMPLETE FOR ELIGIBLE DEPENDENT(S)

Employee's Name: _____ Employee's Social Security #: _____

ELIGIBILITY OR QUALIFYING EVENT CHANGE	LAST NAME	FIRST NAME	BIRTHDAY MO/DAY/YR	SEX	LIST NEW CHANGE (SALARY/ADDRESS, ETC.)	COVERAGES AFFECTED
# EFFECTIVE DATE						

COMMENTS: _____

EMPLOYER'S (OR REPRESENTATIVE'S) SIGNATURE _____ PHONE NUMBER _____ DATE _____

CHANGE OF ADDRESS INSTRUCTIONS FOR OPTIONAL POLICIES OFFERED BY CITY OF STAFFORD

Nationwide - If you participate in the deferred compensation plan, please call 877-677-3678 and choose option *0 to give them your change of address.

Flexible Spending Accounts - Please call 1-800-323-5391 to update your address or you may submit your new address on a reimbursement form.

Aflac Insurance- Please call 1-800-99-AFLAC to update your address