



CHANGE FORM

Missouri Payroll Clerks FAX to: (573) 896-9971

PRINT EMPLOYEE NAME: _____

SSN: _____ EMPLOYEE DAY/WORK PHONE: _____

DEPARTMENT NAME: _____

CANCELLATION OF INSURANCE COVERAGE (*attach signed payroll authorization cancellation*).

INCORRECT SSN:

Our records indicate: _____/_____/_____ is the *correct* SSN.

The payroll authorization form received showed: _____/_____/_____ as the SSN.

NAME CHANGE:

_____ new name

ADDRESS CHANGE: _____

City _____ State _____ Zip _____

CHANGE IN PAYROLL STATUS: (please attach copy of original payroll card)

The employee's last paycheck is/was dated: _____

Transferred dept./division (*NEW* dept./div: _____)

Termination date: _____

Retirement date: _____

Disability

Death

Other/Notes: _____

The employee is on leave without pay, effective date of: _____

The employee has returned to work after leave without pay, effective date: _____

Name of PAYROLL CLERK who completed this form: _____

Dept/Div: _____

Phone: (_____) _____ Email: _____ Date: _____

866-668-5421

MoVLIC PO Box 335, Jefferson City, MO, 65102 573-896-9911