



Change of Address Form

Office of Human Resources, Payroll & Records

1301 West Main • Wilburton, OK 74578

Phone: 918.465.1777 • Fax: 918.465.4421

Name: _____

SSN: _____

Phone: _____

Work Phone: _____

Signature: _____

Date Signed: _____

New Address: _____

Old Address: _____

Effective Date: _____



**Office of Management and Enterprise Services
Employees Group Insurance Department**

3545 NW 58th Street, Suite 110
Oklahoma City, Oklahoma 73112
1-405-717-8780 or toll-free 1-800-752-9475
TDD: 1-405-949-2281 or toll-free 1-866-447-0436
FAX: 1-405-717-8939

Change of Address

Member Name: _____
SSN or Member ID #: _____
Member Phone Number: _____
New Address: _____ _____
Member's Signature: _____
Date: _____

Current Employees – Return this form to your insurance coordinator.

Former Employees – Return this form to EGID at the address or FAX number listed above.



TEACHERS' RETIREMENT SYSTEM OF OKLAHOMA

PO BOX 53524 OKLAHOMA CITY, OKLAHOMA 73152
LOCAL: (405) 521-2387 TOLL FREE: (877) 738-6365

PERSONAL DATA FORM 1A (ACTIVE or NON RETIRED)

All data contained on the Personal Data form must match the data submitted electronically by the employer via monthly contribution reports.

Please designate the reason for completing this form: New Member Name Change Return to Active Contributing
 Position Change District Transfer Address Change Other _____

1.	Social Security Number	Name of School District or Institution	County
	<input type="text"/>	<input type="text"/>	<input type="text"/>

2.	Legal Name (All requests for change of name must include legal documentation [i.e. Marriage Certificate, Divorce Decree, etc.])			
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	(Last Name)	(First Name)	(Middle Name)	(Maiden Name)

3.	Permanent Mailing Address (Address must match address on monthly contribution reports)			
	<input type="text"/>			
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	(City)	(State)	(Zip Code)	

GENDER (OPTIONAL)
<input type="checkbox"/> Male
<input type="checkbox"/> Female
MARITAL STATUS
<input type="checkbox"/> Single
<input type="checkbox"/> Married

4.	Date of Birth		
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	(Month)	(Day)	(Year)

Personal Email Address _____

5. **Date of Employment** _____ **Position you will hold** _____

Hours typically worked per week _____

Position's total number of days worked per Fiscal* year _____

* i.e. 260 days/year for most 12-month employees from July 1 – June 30.

6. **a. Have you ever been a member of the Teachers' Retirement System?**

Yes No

b. Were you a member before starting this job?

Yes No

c. Have you withdrawn an account?

Yes No

7. If the answer to questions No. 6.c. is "yes," please complete the applicable columns listing most recent employment first.

(School District, College or Agency)	(County)	(Year)	(Under What Name)	(Approximate Withdrawal Date)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

I hereby declare and affirm, under penalty of perjury, that to the best of my knowledge and belief, all statements and answers as written or printed herein are full, complete, and true whether or not written by my own hand.

Signature of Member _____ **Date** _____

I certify the above-named employee meets the requirements for membership in the Teachers' Retirement System.

Superintendent / Payroll Officer _____