LSU Health
ADMINISTRATION AND BUSINESS OFFICE

HCSD PERSONAL DATA CHANGE FORM
(For Active/Inactive/Retired Employees)

NOTES: **IF YOU HAVE MEDICAL/HOSPITALIZATION INSURANCE, YOU ARE REQUIRED TO COMPLETE THIS DOCUMENT AND THE OGB ADDRESS/NAME CHANGE FORM**

NAME CHANGES REQUIRE A COPY OF SOCIAL SECURITY CARD

Instructions: Print form(s), complete appropriate fields, sign/date and submit to the Human Resources Department. (The forms may also be scanned and emailed).

Name Change (please print):

Old Name: ______________________________

New Name: ______________________________

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Address Change (please print):

Old Address: ____________________ New Address: ____________________

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Phone number Change (main contact phone number):

Old Number: ____________________ New Number: ____________________

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Check Plans/Benefits (If you have medical insurance, you are required to also complete the OGB change form):

Medical: ____ LSU First ____ OGB Plan ____ Dental ____ Vision
Life Insurance: ____ LSU System ____ OGB/Prudential
Membership In: ____ LASERS ____ TRSL

Employees are responsible for notifying the individual vendor of name/address changes for miscellaneous plans not indicated above, such as Deferred Comp; ORP; Credit Union; etc.

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Print Name: ______________________________ Last 4 digits of SSN: ____________

Signature: ______________________________ Date: ____________

(Submit completed form(s) to the Human Resources Department)