aim medical trust
Your Partner for Municipal Health

City of Bedford

CHANGE OF NAME/ADDRESS Form

SECTION A - Change Information

Effective Date: _____	**Change (check applicable):** ❑ Name ❑ Address

SECTION B - Employee Name Change

EMPLOYEE (PREVIOUS)	First Name	Middle Initial	Last Name
EMPLOYEE (CURRENT)	First Name	Middle Initial	Last Name

SECTION C - Dependent Name Change

EMPLOYEE	First Name	Middle Initial	Last Name
DEPENDENT (PREVIOUS)	First Name	Middle Initial	Last Name
DEPENDENT (CURRENT)	First Name	Middle Initial	Last Name

SECTION D - Address change

First Name	Middle Initial	Last Name	
Home Address		City/State	Zip Code
Email		Home Phone	
Relationship	❑ Employee ❑ Spouse ❑ Dependent	❑ Male ❑ Female	

SECTION E - Signature

_____ _____

Employee/Applicant Signature ***Date***