VERIFICATION/INFORMATION DOCUMENT

Emp. ID#: ________

EMPLOYEE INFORMATION (Please Print)

NAME:	**MAIDEN NAME:**
CURRENT ADDRESS:	**DATE OF HIRE:**
CITY/STATE/ZIP:	**DATE OF BIRTH:**
SOCIAL SECURITY NO.:	**HOME PHONE:**
ANNUAL SALARY:	**EMAIL:**

MARITAL STATUS: (Circle One) Single - Married – Divorced – Separated - Other (Explain____)

SEX: (Circle One) Male Female

ARE YOU HISPANIC OR LATINO? ☐ YES ☐ NO

WHAT IS YOUR RACE: (Select one or more) ☐ White ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

SPOUSE/DOMESTIC PARTNER INFORMATION (Please Print) **SPOUSE ☐ DOMESTIC PARTNER ☐** **MALE☐ FEMALE ☐ (Check one)**

NAME:	**DATE OF MARRIAGE:**
SOCIAL SECURITY NO.:	**DATE OF BIRTH:**

CHILDREN/DEPENDENT INFORMATION (Please Print)

NAME: **Male/Female**	**NAME:** **Male/Female**
SOCIAL SECURITY NO.:	**SOCIAL SECURITY NO.:**
DATE OF BIRTH:	**DATE OF BIRTH:**

NAME: **Male/Female**	**NAME:** **Male/Female**
SOCIAL SECURITY NO.:	**SOCIAL SECURITY NO.:**
DATE OF BIRTH:	**DATE OF BIRTH:**

SIGNATURE ____ **DATE:** ___________________

FOR OFFICE OF HUMAN RESOURCES ONLY

Health Plan Election	Dental Plan Election	Dependent Verification
☐ Individual ☐ Individual/Spouse ☐ Individual/Child(ren) ☐ Family	☐ Individual only ☐ Emp. + One ☐ Family	☐ Marriage Certificate ☐ Birth Certificate ☐ Domestic Partner Form & info ☐ COB Form