



STATUS CHANGE FORM

Name: _____ Effective Date: ____ / ____ / ____

Last 4 Digits of SSN: _____
(Employee only)

Employer's Name: _____
(Not required for vendor.)

Instructions: After completing the section above in full, complete *ONLY* the updated sections below then sign and date. Please submit the completed form to **AssuranceSD** via one of the following options:

Mail:
515 South 700 East,
Suite 2B
Salt Lake City, UT 84102

Email:
UT@premier-fms.com

Fax:
(855) 500-4521

SECTION 1

New Name: _____
Please submit an updated ID when requesting a name change. Vendors, please submit a new W-9 when requesting a name change.

SECTION 2

Address: _____

New Add

SECTION 3

Phone Number: _____

New Add

SECTION 4

Email: _____

New Add

SECTION 5

Last day worked: ____ / ____ / ____ Termination Reason: _____
(Optional)

Re-hire Date: ____ / ____ / ____

Employee Signature: _____ Date: ____ / ____ / ____

Employer Signature: _____ Date: ____ / ____ / ____