Change of Address

Instructions for employee withholding certificate

Dependents - To qualify as your dependent (line 7a) a person must qualify as your dependent as provided in the Federal Internal Revenue Code.

Changes in Exemptions - You should file a new certificate any time the number of your exemptions increases. You must file a new certificate within 10 days if the number of exemptions previously claimed by you DECREASES.

Other Decreases - in exemptions, such as the death of a spouse or dependent, do not affect your withholdings until the next year but require the filing of a new certificate by December 1 of the year in which they occur.

Change of Residence - You must file a new certificate within 10 days after you change your residence from or to a taxing city.

Additional withheld - You may designate additional withholding if you expect to owe more than the amount withheld.

BC W-4

EMPLOYEES WITHOLDING CERTIFICATE FOR THE CITY OF BATTLE CREEK INCOME TAX

1. Print full name	2. Social Security Number	3. Battle Creek Resident? Yes ○ No ○

4. Address	City, Township or Village where you reside	State	Zip Code
		Michigan	

Employee - File this form with your employer, otherwise your employer must withhold Battle Creek income tax from your earnings without exemptions.

Employer - Keep this certificate with your records. If the information submitted by the employee is not believed to be true, correct and complete,and the Battle Creek Income Tax Department must be so advised.

Check boxes that apply

5. Exemptions for yourself:	☐ Regular Exemption	☐ Age 65 & older or Disabled	☐ Blind	☐ Deaf	Enter number of exemptions checked	
6. Exemptions for your spouse:	☐ Regular Exemption	☐ Age 65 & older or Disabled	☐ Blind	☐ Deaf	Enter number of exemptions checked	
7a. Exemptions for your children Number ☐		7b. Exemptions for your other dependents Number ☐			Enter total of line 7 (a plus b)	
8. Add the number of exemptions which you have claimed on lines 5, 6, 7 a & b above and write the total.					**Total**	
8. Additional amount you want deducted from each pay (if employer agrees)						

I certify that the information submitted on this certificate is true, correct and complete to the best of my knowledge and belief.

Date Signature

Department of Technology, Management & Budget
Office of Retirement Services
www.michigan.gov/ors (800) 381-5111
P.O. Box 30171
Lansing MI 48909-7671

Name, Address, and Contact Information Change

For Retirees

MEMBER'S NAME (LAST, FIRST, M.I.)	MEMBER ID OR SSN	DATE OF BIRTH
CURRENT MAILING ADDRESS		TELEPHONE NUMBER ( )
CITY, STATE, ZIP CODE		EMAIL ADDRESS

Your change(s) will take effect once we receive and process your request, which may take up to 30 days.
Want it faster? Use miAccount at **www.michigan.gov/orsmiaccount** to make a same-day change.

Name Change

Fill out this section if you are changing your name. Provide legal documentation of your name change such as a copy of a marriage certificate, divorce decree, or Social Security card.

NEW LAST NAME	FIRST NAME	M.I.

Physical Address Change

Fill out this section if you are changing the address where you live. Your physical address cannot be a PO Box.
Moving to a foreign address? Contact ORS at (800) 311-5111 for further instructions.

PHYSICAL ADDRESS (CANNOT BE A PO BOX)	APT OR SUITE
CITY STATE, ZIP CODE	COUNTY OF RESIDENCE

Mailing Address Change

Fill out this section if you are changing the address where you receive your mail.

☐ CHECK IF SAME AS PHYSICAL ADDRESS

MAILING ADDRESS (IF SAME AS PHYSICAL, LEAVE BLANK)	APT OR SUITE
CITY, STATE, ZIP CODE	

Certification

This form must be signed before it can be processed. If a member is unable to sign, the endorser must enclose a copy of his or her authorization of guardianship, power of attorney, or conservatorship.

APPLICANT SIGNATURE _____ DATE _____

Return your completed form and any attachments to:
ORS, P.O. Box 30171, Lansing, MI 48909-7671

R0357X (Rev. 10/2015)
Authority, as amended: 1980 PA 300; 1943 PA 240; 1986 PA 182; 1992 PA 234

MESSA
Good health. Good business. Great schools.

1475 Kendale Blvd., PO Box 2560
East Lansing, MI 48826-2560
Questions? Call 888.888.4167
Fax 517.203.2914

Member Change Form

This form is designed to make any of the changes listed below. Please fill out completely, sign and return to your employer. The signed form **must be submitted within 31 days** of the requested qualifying event or change to ensure timely processing.

MESSA Member Information *(Required)*

SSN or MESSA ID#: _____

CURRENT Name and Address Information			NEW Name and Address Information		
First Name	Last Name		First Name	Last Name	
Address		Apt. #	Address		Apt. #
City	State	Zip Code	City	State	Zip Code
Home Phone ( )			Home Phone ( )		
Email			Email		

Effective Date: _____

Important Reminder: *Do you need to change or update your life insurance beneficiary? You can obtain a* ***Beneficiary Designation Form*** *online at www.messa.org or by calling MESSA at 888.888.4167.*

Change Code(s) *(check all that apply)*

Qualifying Events: All changes submitted on this form outside of open enrollment must be due to a qualifying event. ***Social Security Numbers are required for all dependents.**

- ☐ 1 **Marriage:** ***Date of Marriage:*** _____ To add a spouse or dependent(s) complete Sections 1 & 3
- ☐ 2 **Birth:** To add a newborn complete Section 1. Remember to submit Social Security Numbers for newborns when issued.
- ☐ 3 **Adoption:** To add an adopted child complete Section 1.
- ☐ 4 **Legal Guardianship:** To add a dependent(s) complete Section 1.
- ☐ 5 **Sponsored Dependent:** Complete Section 1 to add. There is an additional cost for this coverage and MESSA requires IRS verification.
- ☐ 6 **Divorce:** ***Date of divorce:*** _____ To delete a spouse and any applicable dependents complete Sections 1 & 3.
- ☐ 7 **Other Eligible Dependents:** To add an eligible dependent not listed above complete Section 1.

Other Changes:

- ☐ 8 **Delete Dependent:** To delete dependent(s) complete Section 1.
- ☐ 9 **Cancel Variable Options:** To cancel variable options complete Section 2. *Cancellation of non-PAK Medical requires a Member Application.*
- ☐ 10 **Dental Coordination of Benefits:** To change dental coverage complete Section 3.
- ☐ 11 **Legal Name Change:** To change name other than through marriage or divorce requires legal documentation.

Section 1: Dependents *(All information requested below is required to add or delete a dependent. Only list the dependents affected by the indicated change code.)*

First Name	Last Name	Gender M F	Date of Birth (mm/dd/yyyy)	*Social Security Number	Relationship to Member	Change Code (See Above)	Requested Effective Date (mm/dd/yyyy)
		☐ ☐					
		☐ ☐					
		☐ ☐					
		☐ ☐					

Section 2: CANCEL Variable Options

Effective Date: _____

- ☐ Optional Short Term Disability (STD)
- ☐ Optional Long Term Disability (LTD)
- ☐ Optional Dependent Life
- ☐ Optional Survivor Income Insurance (SII)
- ☐ Optional Hospital Confinement (HCI)
- ☐ Optional Supplemental Term Life
- ☐ Optional Basic Term Life (BTL)

Note: if you are enrolled in Non-PAK Medical, you may ***not*** cancel BTL.

Section 3: Dental Coordination of Benefits

Effective Date: _____

Do you, your spouse or dependents have dental coverage through another source? ☐ Yes ☐ No Who is covered through the source? ☐ Self ☐ Spouse ☐ Dependents

Employee Signature	Date
Authorized Employer Signature and Stamp	Date