Employee ID # _______________

STAFFORD COUNTY PUBLIC SCHOOLS

Benefits Office
31 Stafford Avenue Stafford, VA 22554

RETIREE INFORMATION UPDATE FORM

NAME: ____

MARITAL STATUS: ____

CURRENT ADDRESS: ____

____

HOME PHONE: ____

CELL PHONE: ____

EMAIL ADDRESS: ____

NAME OF SPOUSE (IF APPLICABLE): ____

EMERGENCY CONTACT:

NAME: ____

RELATIONSHIP: ____

PHONE: __________________________ **EMAIL:** __________________________

_____I authorize Stafford Schools Benefits Office to discuss my health/dental benefit account information with the above-listed individuals as needed. **THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING AND PROVIDED TO THE SCPS BENEFITS OFFICE**.

____ I DO NOT authorize Stafford Schools Benefits Office to discuss my health/dental benefit account information with the above-listed individuals.

RETIREE SIGNATURE: ___________________________________ **DATE:** ________________

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Office Use Only

Received By: ____ **Date:** ____________

Entered By: ____ **Date:** ____________