

**LAFAYETTE COLLEGE**  
**ACTIVE EMPLOYEE CHANGE OF ADDRESS FORM**

Please Print

NAME \_\_\_\_\_

NEW ADDRESS \_\_\_\_\_

\_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_

EFFECTIVE DATE \_\_\_\_\_

**MEDICAL INSURANCE:**

Group # \_\_\_\_\_

Identification or Social Security # \_\_\_\_\_

Please indicate your current insurance coverage:

- Capital Blue Cross PPO
- Keystone HMO
- US Healthcare HMO
- Waive
- Dental

Signature \_\_\_\_\_

PLEASE RETURN TO OFFICE OF HUMAN RESOURCES, 12 MARKLE HALL  
LAFAYETTE COLLEGE, EASTON, PA 18042