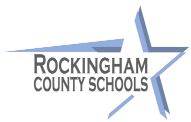

Request For Change of Name, Address or Phone Number

Office of Human Resources - 511 Harrington Highway, Eden, North Carolina 27288

Request Type (Check all that apply):

☐ Name Change **(Email address will change)**
☐ Address Change
☐ Phone Number Change **(This will also change the # used for alert calls & frontline absence management calls)**

Name on current records: ____

New Name (if requesting name change): ____

Last 4 digits of Social Security Number: XXX - XX - ____________

School/Department: ____

Position/Grade/Subject: ____

Home Address: ____

City: ______________________ State: ____________ Zip: ________________

Main Telephone #: ______________________ (This number will be used for all communication to employee)

Alternate Telephone #: ______________________

Employee Signature: ______________________ Date: ________________

Please submit this form to the Office of Human Resources at the address above.

Name Changes will require:
- Copy of new social security card
- $10.00 for a new identification badge
- This Form (Request for Change of Name, Address or Phone Number)
- North Carolina State Tax Withholding Allowance Certificate (NC4ez)
- Internal Revenue Service (Form W-4)
- Flexible Benefits Change Form (for name change of supplemental plans Dental, Vision, FSA, Colonial life, etc.)
- Colonial Life & Accident Insurance Company (form 05897-31)
- Colonial Life Change of Beneficiary Form

Licensed Employees will also require the following:
- NC Teacher License update - Go to https://vo.licensure.ncpublicschools.gov/
  - Create a username and password (If you haven't already done so)
  - Select Application: Name Change (The new copy of your social security card must be uploaded)
  - Follow the instructions thereafter.

NOTE:
- If you would like to change the Beneficiary(ies) you have designated with the Retirement System go to www.myncretirement.com , click on ORBIT register yourself and click on View Account Summary to review your current Beneficiary(ies). To make a change click on Maintain Beneficiary and update the information online.
- The Human Resource Department will make the changes and then forward it to the Finance Department and the Media & Technology Department for them to make the changes necessary (**including changing email address for name changes and printing a new identification badge**).

If you have any questions, please contact Catherine Gates in Human Resources at 336-627-2692.
****** Incomplete forms will be returned without processing ******

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ ________

Multiply the number of other dependents by $500 . . . . . $ ________

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . | **3** | $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . | **4(a)** | $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . | **4(b)** | $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . | **4(c)** | $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

NCDOR
Web
11-21

NC-4EZ
Employee's Withholding Allowance Certificate

Filing Status (Mark one box only) ☐ Single or Married Filing Separately ☐ Head of Household ☐ Married Filing Jointly or Surviving Spouse

Social Security Number ☐☐☐-☐☐-☐☐☐☐

First Name | M.I. | Last Name

Address | County (Enter first five letters)

City | State | Zip Code | Country (If not U.S.)

Instructions. Use Form NC-4EZ if you:

- Plan to claim the N.C. Standard Deduction
- Plan to claim the N.C. Child Deduction Amount (but no other N.C. deductions)
- Do not plan to claim N.C. tax credits
- Qualify to claim exempt status (See Lines 3 or 4 below)

Important. If you plan to claim N.C. itemized deductions or plan to claim other N.C. deductions (other than the N.C. Child Deduction Amount), you must complete Form NC-4. If you are a nonresident alien, you must complete Form NC-4 NRA. In general, a nonresident alien is an alien (not a U.S. citizen) who has not passed the green card test or the substantial presence test. *(See Publication 519, U.S. Tax Guide for Aliens, for more information on the green card test and the substantial presence test.)*

If you plan to claim the N.C. Child Deduction Amount, use the table below for your filing status, amount of income, and number of children under age 17 to determine the number of allowances to enter on Line 1. For married taxpayers, only one spouse may claim the allowance for the N.C. Child Deduction Amount for each child.

Single & Married Filing Separately

Income	# of Children under age 17									
	1	2	3	4	5	6	7	8	9	10
	# of Allowances									
0 - 20,000	1	2	3	4	6	7	8	9	10	12
20,001 - 30,000	1	2	3	4	5	6	7	8	9	10
30,001 - 40,000	0	1	2	3	4	4	5	6	7	8
40,001 - 50,000	0	1	1	2	3	3	4	4	5	6
50,001 - 60,000	0	0	1	1	2	2	2	3	3	4
60,001 - 70,000	0	0	0	0	1	1	1	1	1	2
70,001 and over	0	0	0	0	0	0	0	0	0	0

Married Filing Jointly & Surviving Spouse

Income	# of Children under age 17									
	1	2	3	4	5	6	7	8	9	10
	# of Allowances									
0 - 40,000	1	2	3	4	6	7	8	9	10	12
40,001 - 60,000	1	2	3	4	5	6	7	8	9	10
60,001 - 80,000	0	1	2	3	4	4	5	6	7	8
80,001 - 100,000	0	1	1	2	3	3	4	4	5	6
100,001 - 120,000	0	0	1	1	2	2	2	3	3	4
120,001 - 140,000	0	0	0	0	1	1	1	1	1	2
140,001 and over	0	0	0	0	0	0	0	0	0	0

Head of Household

Income	# of Children under age 17									
	1	2	3	4	5	6	7	8	9	10
	# of Allowances									
0 - 30,000	1	2	3	4	6	7	8	9	10	12
30,001 - 45,000	1	2	3	4	5	6	7	8	9	10
45,001 - 60,000	0	1	2	3	4	4	5	6	7	8
60,001 - 75,000	0	1	1	2	3	3	4	4	5	6
75,001 - 90,000	0	0	1	1	2	2	2	3	3	4
90,001 - 105,000	0	0	0	0	1	1	1	1	1	2
105,000 and over	0	0	0	0	0	0	0	0	0	0

1. **Total number of allowances you are claiming** *(Enter zero (0), or the number of allowances from the table above)* ________

2. **Additional amount, if any, you want withheld from each pay period** *(Enter whole dollars)* ________________.00

3. **I certify that I am exempt from North Carolina withholding because I meet both of the following conditions:** Check Here ☐
   - Last year I was entitled to a refund of all State income tax withheld because I had no tax liability; **and**
   - This year, I expect a refund of all State income tax withheld because I expect to have no tax liability.

4. **I certify that I am exempt from North Carolina withholding because I meet the requirements set forth in the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act and Veterans Benefits and Transition Act.** ***(See Form D-401, North Carolina Individual Income Tax Instructions, for more information.)*** Check Here ☐

   If an exemption on Line 3 or Line 4 applies to you, enter the year the exemption became effective ________ YYYY

5. **I certify that I no longer meet the requirements for an exemption on Line 3** ☐ **or Line 4** ☐ *(Check applicable box)*

   Therefore, I revoke my exemption and request that my employer withhold North Carolina income tax based on the number of allowances entered on Line 1 and any additional amount entered on Line 2. Check Here ☐

CAUTION: If you furnish an employer with an Employee's Withholding Allowance Certificate that contains information which has no reasonable basis and results in a lesser amount of tax being withheld than would have been withheld had you furnished reasonable information, you are subject to a penalty of 50% of the amount not properly withheld.

Employee's Signature ________________________________ **Date** ________________

I certify, under penalties provided by law, that I am entitled to the number of withholding allowances claimed on Line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on Line 3 or 4, whichever applies.

Colonial Life & Accident Insurance Company

REQUEST FOR SERVICE: What type of service are you requesting? Please check only the boxes that apply.

1 GENERAL INFORMATION

Insured's name as currently listed on the policy:	Social Security Number (SSN):	Date of Birth(mm/dd/yyyy):

List all policy numbers related to this request (required to process):

Employer Name:

2 NAME CHANGE
Please attach a copy of legal evidence.

Previous Name:	**Current Name:**	**Reason:** ☐ Correction ☐ Marriage/Divorce ☐ Other

3 ADDRESS CHANGE

Address:	**Apt. #:**	**City:**	**State:**	**ZIP:**

Telephone: ( )	**Mobile:** ( )	**Email:**

4 REQUEST FOR CHANGE OF BENEFICIARY FORM

☐ Please visit us at our website, coloniallife.com, or contact us at 1.800.325.4368 to request a copy of the Change of Beneficiary form.

5 PREMIUM PAYMENT METHOD CHANGE
Please select one of three easy payment methods.

☐ **1. Please deduct monthly premiums from my banking account.**

RANGE: **A).** 1st-5th **B).** 6th-10th **C).** 11th-15th **D).** 16th-20th **E).** 21st-26th. Your draft will occur on one of the dates within the range you have selected.

Please attach a voided check, and circle one range of days you would like your checking account to be drafted.

Signature of checking account owner: ____________________

OR

☐ **2. Please bill me directly.**

Choose one of the following:

☐ **Quarterly** (Submit a payment 3 times your monthly premium.)

☐ **Semi-annually** (Submit a payment 6 times your monthly premium.)

☐ **Annually** (Submit a payment 12 times your monthly premium.)

OR

☐ **3. Change to Payroll Deductions.**

Employer Name: ____________________

Billing Control Number or Account Number: ____________________

Please contact your Plan Administrator to start payroll deduction.

6 CANCELLATION, SURRENDER OR POLICY CHANGE
You must also complete **Sections 9 and 12** on the reverse side.

☐ **Cancel/surrender the policy/policies** **(This option will cancel or cash surrender your policy/policies.)**

Cancel the following riders on the policy/policies: **(This option will cancel policy riders only.)** ☐ Spouse Rider ☐ Dependent Rider (This will cancel coverage for ALL dependents.) ☐ Other (name rider) ____________________

☐ Change Two-Parent to Individual	☐ Change Two-Parent to One-Parent	☐ Change One-Parent to Individual

Please provide name, birthdate, and social security number for spouse/dependent(s) continuation:	Name:	Date of Birth:	SSN:
	Name:	Date of Birth:	SSN:

7 POLICY LOAN
You must complete **Sections 9 and 12** on the reverse side. Select either Section **7 or 8** per policy number, **not both.**

Please select ONE option per policy number.	☐ I am requesting a policy loan for the following amount: $____________ ☐ I am requesting a policy loan for the maximum amount available.	If the amount requested is more than the available cash value, we will process this request for the maximum amount available.

☐ **Check this box also if you are requesting information regarding repayment of your loan on your Universal Life policy.**

By signing on the reverse side, I hereby assign the policy to the insurer as collateral.

Policy loans are available on select life policies only. Minimum loan amounts may apply as stated in your policy contract. You will receive annual loan and interest notices until the loan is fully repaid. For information regarding repayment of your loan, please contact us at 1.800.325.4368.

Continued on Reverse Side ➡

8 WITHDRAWAL/PARTIAL SURRENDER (Universal Life Policy) Complete **Sections 9 & 12.** Select either Section **7 or 8** per policy number, **not both.**

Please select ONE option per policy number.	☐ I am requesting a policy withdrawal/partial surrender for the following amount: $____________ ☐ I am requesting a policy withdrawal/partial surrender for the maximum amount available.	If the amount requested is more than the available cash value, we will process this request for the maximum amount available.

Only one policy withdrawal/partial surrender is allowed per policy year. Minimum withdrawal amounts apply as stated in your policy contract. There will be a processing fee as stated in your policy contract. Policy withdrawals/partial surrenders are available on universal life policies only. If your policy is not a universal life policy and you request a withdrawal, we will process the request as a policy loan.

9 TAX WITHHOLDING OPTIONS Please read and complete this section if you are requesting a surrender or withdrawal.

Election of a tax withholding option is not available for tax-qualified products. The insurer is required to withhold 20% of any recognized gain for tax-qualified products unless proceeds are rolled directly into an IRA or other qualified retirement plan.

Under certain criteria established by the Treasury Department, a gain may be reportable by the insurer at the time of surrender, partial surrender or withdrawal of this policy, creating a taxable situation. However, any gain is taxable income for the current tax year.

If a gain is reportable, an IRS Form 1099R will be sent to you at the beginning of the next calendar year reporting the recognized gain, and a copy of Form 1099R will be sent to the IRS. If a gain is not reportable when the surrender, partial surrender or withdrawal is processed, an IRS Form 1099R will not be sent. In addition, if a gain is reportable, the insurer is required to withhold 10% of any recognized gain, unless the policy owner elects not to have the tax withheld. You may be subject to penalties under the estimated tax payment rules if you elect not to have tax withheld and payments of estimated tax and other withholding are not adequate to satisfy tax liability.

Choose one of the following options. If an option is not selected, a withholding will automatically be made.

☐ I **DO NOT** want to have Federal Income Tax withheld in conjunction with this surrender/partial surrender/withdrawal.

☐ I **DO** want to have Federal Income Tax withheld from the surrender/partial surrender/withdrawal proceeds.

10 SPECIAL NOTICE FOR RESIDENTS OF A COMMUNITY PROPERTY STATE

A spouse or former spouse may have an interest in life insurance proceeds or any accumulated cash value if the policy premiums were paid with community funds. It is your responsibility to consult your legal advisor to 1) ensure that any required consent from a spouse or former spouse has been received and 2) ensure that your spouse or former spouse will not be able to make a claim against any policy values and/or the proceeds in the event any policy benefits become payable.

11 OTHER REQUESTS OR REMARKS Includes illustration changes, policy face value decrease, age discrepancies, or premium increase, etc.

____

____

12 SIGNATURES REQUIRED You must fill out this section **COMPLETELY** in order for us to process your request.

➡ BE SURE TO LIST A SOCIAL SECURITY NUMBER AND DATE OF BIRTH BELOW. FAILURE TO PROVIDE THIS INFORMATION MAY DELAY PROCESSING.

I have carefully read this request and agree that it is properly and fully completed. I understand that this request is subject to the provisions and conditions of the policy and that the company may require additional information or requirements. I certify that the policy is not pledged or assigned to any other person or corporation, except where stated in the request, and that no proceedings or bankruptcy or insolvency have been filed or are now pending.

*I certify the **Social Security Number** and **Date of Birth** indicated are correct, and I hereby authorize Colonial Life to execute this request.*

Print Policy Owner's Name:______________________________ Policy Owner's Social Security Number:______________

Policy Owner's address:______________________________ **AND** Policy Owner's Date of Birth:______________

____

Policy Owner's Email Address: ______________________________ Daytime Telephone:______________

Policy Owner's Signature:______________________________ **Date:** (MM/DD/YYYY)______________

Assignee's signature (if any):______________________________ Date: (MM/DD/YYYY)______________

MAIL TO: Colonial Life & Accident Insurance Company, P.O. Box 1365, Columbia, SC 29202-1365
Phone: 1.800.325.4368 / To fax requests: 1.800.561.3082 coloniallife.com

CHANGE OF BENEFICIARY FORM

(Please print all information clearly)

Named Insured ____ Social Security Number ______________________
LAST FIRST MI

Policy Number(s) ____

❑ Please apply change of beneficiary to all Colonial Life policies I currently own that allow for a beneficiary designation.

Policyowner's Name ____ Social Security Number ______________________
LAST FIRST MI

Policyowner's Mailing Address (Address on file will be updated to the address provided below.)

Street Address ____ Email ______________________________

City ________________________________ State __________ Zip ___________ Phone (_______) ____________________

***IMPORTANT – PLEASE READ BEFORE DESIGNATING A BENEFICIARY**
The person(s) designated as Primary Beneficiary will receive any payable benefits. If the Insured outlives all Primary Beneficiaries designated, any payable benefits will be made to the designated Contingent Beneficiaries. If the Insured outlives all named Primary and Contingent Beneficiaries, any payable benefits will be made according to the terms of the policy. Contact us at 1-800-325-4368 if additional space is needed to designate all desired beneficiaries.

Primary Beneficiary(s): All surviving Primary Beneficiaries will receive equal amounts of the proceeds (unless percentages or amounts are indicated). If more than one Primary Beneficiary is named, the total % must equal 100%.

Name (Last, First, MI)	**%**	**Relationship**	**Date of Birth** (MM/DD/YY)	**Social Security Number**

Contingent Beneficiary(s): If the Named Insured out-lives all Primary Beneficiaries, all surviving Contingent Beneficiaries will receive equal amounts of the proceeds (unless percentages or amounts are indicated). If more than one Contingent Beneficiary is named the total % must equal 100%.

Name (Last, First, MI)	**%**	**Relationship**	**Date of Birth** (MM/DD/YY)	**Social Security Number**

Grandchildren's Clause: ❑ Check this box to ensure that in the event a Primary or Contingent Beneficiary who is a son or daughter of the insured is no longer living at the time of the Insured's death, their portion of the policy proceeds will be paid equally to their surviving legal children.

Special Notice for Residents of a Community Property State: A spouse or former spouse may have an interest in life insurance proceeds or any accumulated cash value if the policy premiums were paid with community funds. It is your responsibility to consult your legal advisor to: 1) ensure that any required consent from a spouse or former spouse has been received; and 2) ensure that your spouse or former spouse will not be able to make a claim against any policy values and/or proceeds in the event any policy benefits become payable.

I request this beneficiary designation replace all prior designations for the policy(s) listed above.

Signature of present policyowner ____ Date ____________
MM/DD/YYYY

Signature of witness ____ Date ____________
Must be someone other than the insured, a designated beneficiary and the policyowner MM/DD/YYYY

Print name and address of witness

____
Last First MI Street Address City State Zip

Changing your beneficiary is a very serious matter. To ensure your beneficiaries receive their proceeds in the manner you desire, without any delays or disputes, it is extremely important that the form is completed correctly. Before completing this form, we suggest you visit our website at ColonialLife.com for additional information on changing beneficiaries.

Once Colonial Life receives and approves this form, all other beneficiary designations are null and void. This means if you want any of the beneficiaries previously named to continue as a beneficiary, you must include their names on the new Change of Beneficiary Form.

If you want to have the proceeds distributed through a Trust, please contact us for additional instructions on naming a Trust(ee) as beneficiary.

Instructions

- The policyowner must complete this form in its entirety.
- Print all information on the form in ink to ensure it is legible. It is extremely important we record your beneficiary designation(s) correctly.
- You must designate a primary beneficiary(s).
- You may also choose to designate a contingent beneficiary(s). A contingent beneficiary is the person or persons to receive benefits if no one listed as primary beneficiary is living at the time of the insured's death.
- You can designate one or more primary or contingent beneficiaries. Contact us if you need more space than provided on this form.
- You must give the full name of each beneficiary and their relationship to the insured (person whose life is covered by the policy). For example, John Jacob Doe, spouse.
- Life insurance proceeds cannot be paid to a minor beneficiary or to the natural parents of a minor for the child's benefit. Unless there is a court appointed legal custodian or legal guardian (conservator) for the child's estate named by the probate court, Colonial Life will be forced to hold the proceeds (with interest earned on the funds) until the minor reaches the age of majority for the state in which the child resides.
- If this policy has a Cash Draft (located on the Policy Schedule page of the policy), and you return the policy with this Change of Beneficiary Form, we will reissue the cash draft to the new beneficiary. Note: Cash Drafts cannot be reissued to funeral homes, minors, trusts, estates or multiple beneficiaries.
- The policyowner must sign the form in ink and print their name and address.
- A witness must sign the form in ink and print their name and address. The witness must be someone other than the insured, the designated beneficiaries listed on the form, or the policyowner.
- Mail or fax this form to:

  Colonial Life
  P.O. Box 100130
  Columbia, SC 29202-1365

  Fax: 1-877-828-9430

- You will receive a letter of confirmation when the change has been completed. If there is a provision in this policy which requires that a beneficiary change be endorsed upon the policy, it is now waived and the desired beneficiary change will be effective, once received and approved by Colonial Life, as of the date it was signed. We will confirm the change by U.S. Mail.

Flexible Benefits Plan
Change Form

Employer/Employee Information

Employer: ____Group #:___________ Date:_____________
Employee: ____
Social Security Number:_________________________ Number of Deductions:_______________________
Address:____
****Please check the appropriate box and complete applicable portions.****

☐ **Employee Family Status Change**
The change that occurred is *(check one)*: ☐ Marriage ☐ Divorce ☐ Adoption ☐ Birth ☐ Death
Spouse's Employment: ☐ Changed ☐ Ended
☐ Other Change *(please explain)*:____
Effective Date of Change:____

☐ **The above named employee <u>has resigned</u> effective ____________. Please stop flexible spending benefits effective ____________.**
Year to Date Deductions: Health Care____________ Dependent Care____________

☐ **The above named employee <u>has gone on a leave of absence</u> and payments for flexible spending have been discontinued effective ____________.**
Year to Date Deductions: Health Care____________ Dependent Care____________

☐ **The above named employee <u>has returned from a leave of absence</u> and will have ________/mo. dollars taken out of their check for the next ________ months for flexible spending accounts.**
Date Deduction will Start:________________
New Annualized Plan Year Election Amount: Health Care____________ Dependent Care____________

Employee Revision Information

****Indicate revised amounts and complete applicable portions.****

	Current Amount	**Revised Amount**
Group Medical Premium		
Colonial Pre-tax Products		
Colonial Post-tax Products		
Group Dental Premium		
Group Term Life Premium		
Vision Premium		
Other Premium		
DEPENDENT CARE FSA	**$ /month** **$ /year**	**$ /month** **$ /year**
HEALTH CARE FSA	**$ /month** **$ /year**	**/month** **$ /year**

I certify that the above designated changes are accurate and correct. I also understand that changing my salary reduction(s) to zero will terminate my participation in the designated account(s) or plan(s). My benefit election and compensation reduction agreement shall remain in effect as to my benefit coverages, except as indicated above.

Employee Signature____ Date:_________________

I certify and authorize the above:

Plan Administrator Signature_______________________________________ Date:_________________