Participant Name	Employer Name	Employee Name

KS WORK UnitedHealthcare
Employee Change of Information

Address/Name Change (Please Print)					
Former Name:			New Name:		
Former Address:			New Address:		
City:	State:	Zip:	City:	State:	Zip:
PA/Employee SSN:	Name of participant for whom you work:		Participant ID:		

If you are completing this form because of a name change, please send this form and a copy of your new social security card to the KS WORK program, through Public Partnerships LLC. We will need a copy of this card, along with this form, signed and completed, before the change will take effect.

PA/Employee Signature _____ Date _____

Please call us toll free at 1-877-908-1747 if you have any questions. TTY users please dial toll free at 1-800-360-5899.

Send completed and signed form to the KS WORK program, through PPL via fax, email, or mail

Fax*	**Email***	**Mail**
1-855-344-5443	pplks-unitedhealthcare@pplfirst.com	KS WORK UHC Public Partnerships LLC 17 Plaza Drive, Suite 300 Latham, NY 12110
***FOR FASTEST PROCESSING, EMAIL OR FAX FORMS**		

NOTE: Information provided on this form is confidential and is treated as such. Completion of this data is voluntary and will not affect your employment status. Identification can be declared at any time prior to, or if applicable, after hire.