DEM 100

Title	Rev.	Page
CITY OF SAN JOSE CAPITAL OF SILICON VALLEY Office of Retirement Services	**Change of Address Form**	**06/27/22**	**1 of 1**

Name:____ **Last 4 digits of SSN:**______________

E-Mail Address: ____

1. Please print or type and sign the form. **All changes require a wet signature for processing.**
2. Contact the Office of Retirement Services at 408/794-1000 or 800/732-6477 if you have questions.
3. Return the form using one of the following methods:
   - Mail to: **City of San José- ORS 1737 N. First St Suite 600 San José, CA 95112**
   - Fax to: **(408) 392-6732**
   - Upload via: MemberDirect
   - Email scanned PDF document to: **retirement.dept@sanjoseca.gov**

HOME ADDRESS: HOME ADDRESS REQUIRED FOR INSURANCE PURPOSES. **NO PO BOXES.**				
FORMER HOME ADDRESS:				Home Phone #
Number	Street	City, State	Zip	Cell #
CURRENT HOME ADDRESS:				Home Phone #
Number	Street	City, State	Zip	Cell #

MAILING ADDRESS (if different than the HOME address):			
FORMER MAILING ADDRESS:			
Number	Street	City, State ,	Zip
CURRENT MAILING ADDRESS:			
Number	Street	City, State	Zip

CALIFORNIA TAXES (Applies only if you are moving out of California)

In compliance with Federal Law, California income tax is not to be withheld from pension recipients who reside outside of California. If you are moving outside of California, Retirement Services will terminate your California State Income Tax withholdings as of the effective date below. If this is a temporary change or you are **NOT** changing your legal residency and would like to continue your State of California Personal Income Tax Withholding, **check the following box:**

☐ **Continue withholding State of California Income Taxes**

HEALTH INSURANCE COVERAGE IMPACTS

HMO plans have zip code service area requirements. If you're moving to a new zip code, go to www.sjretirement.com, navigate to the Health Benefits > Medical page, and review the zip code requirements document for your medical plan. If your current medical plan is not available in your new zip code, you must elect a new plan by submitting an INS100 form within 30 days of your move date. **Please note:** Medicare Advantage plans require vendor disenrollment and enrollment forms for the specific plan you're selecting in addition to an INS100 form. Forms are available on our website under the Forms tab.

☐ **I have verified that my new address meets eligibility requirements for my current medical plan.**

☐ **My new address is out of the service area for my current medical plan. I am attaching a Health Enrollment Change form or will submit one within 30 days of my address change.**

Retiree/Survivor or POA* Signature:____________________________**Effective Date:**

*Must have Power of Attorney Documentation in member's file or submission with this form.