WasatchSD
Part of the AssuranceSD Family

DIRECT CARE PROFESSIONAL/EMPLOYEE STATUS CHANGE

Direct Care Professional/Employee Name Full Name: _____

Effective Date: _____

Last 4 Digits of SSN: _____
(Direct Care Professional Only)

Employer Full Name: _____

Instructions: After completing the section above, complete **ONLY** the updated sections below then sign and date. Please submit the completed form to WasatchSD via one of the following options:

Mail
515 South 700 East
Suite 2B
Salt Lake City, UT 84102

Email
info@WasatchSD.com

Fax
855.500.4521

SECTION 1: NAME CHANGE

New Name: _____
Please submit an updated ID when requesting a name change.

SECTION 2: ADDRESS CHANGE

Address: _____

City: _____ State: _____ Zip: _____

☐ New ☐ Add

SECTION 3: PHONE NUMBER CHANGE

Phone Number: _____ ☐ New ☐ Add

SECTION 4: EMAIL CHANGE

Email: _____ ☐ New ☐ Add

SECTION 5: EMPLOYMENT CHANGE

Last Day Worked: _____ Termination Reason: _____
(Optional)

Re-Hire Date: _____

_____ _____
Direct Care Professional/Employee Signature Date

_____ _____
Employer Signature Date