

Superior Court of California  
County of Santa Clara

Human Resources

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**RETIREE/SURVIVOR OF RETIREE CONTACT INFORMATION CHANGE FORM**

Retiree       Survivor of Retiree

**SECTION 1: Participant Information**

Full Name (*First Name, Middle Initial and Last Name*): \_\_\_\_\_

If Survivor of Retiree, please provide name of Retiree: \_\_\_\_\_

Retiree ID or last 4 of SSN: \_\_\_\_\_

**SECTION 2: New Contact Information – Home Address**

In care of (*if applicable*): \_\_\_\_\_

Address: \_\_\_\_\_

PO Box: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Province/Territory: \_\_\_\_\_ Country: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**SECTION 3: New Contact Information – Mailing Address**

In care of (*if applicable*): \_\_\_\_\_

Address: \_\_\_\_\_

PO Box: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Province/Territory: \_\_\_\_\_ Country: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**SECTION 4: I authorize, \_\_\_\_\_, to  send/receive email,  speak, and/or**  
(First Name Last Name)

send/receive official notices to/from the Court regarding my Retiree Health benefits (*check all that apply*).

**SECTION 5: Required Signature**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_