

CITY OF SAGINAW

EMPLOYEE DEPENDENCY STATUS REPORT

NAME _____ **DEPARTMENT** _____

ADDRESS _____ **PHONE ()** _____

CITY, STATE, ZIP CODE

List fully all persons who receive any contribution from you for their support.

NAME	RELATIONSHIP	DATE OF BIRTH	ADDRESS (if different)	SOCIAL SECURITY #

It is your responsibility to keep the Office of Employee Services informed at all times of your dependency status, such as marriage, divorce, remarriage, removal of listed dependent or addition of a new dependent.

EMERGENCY CONTACT INFORMATION

List names, addresses and phone numbers of two persons who could be contacted in case of an emergency.

NAME	RELATIONSHIP	ADDRESS	PHONE
1. _____	_____	_____	_____
2. _____	_____	_____	_____

IMPORTANT: It is extremely important that the Office of Employee Services be advised promptly of any change in the status of the employee from that stated above so that corrected information is available in the event of an emergency.

DATE _____ **SIGNATURE** _____