ARCHDIOCESE OF LOUISVILLE NOTIFICATION OF EMPLOYEE BENEFIT CHANGE

Employee Name	PARISH/ORGANIZATION				_ Group	o <u>#</u>	
Employee Name	**SEND	COMPLETED FO	RM TC	PERS	SONNEL OF	FICE**	
Employee Name	☑ Check Items to Change						
□ Street Address □ City/State/Zip □ Work □ City/State/Zip □ Work □ Coty/State/Zip □ More □ Annual Salary as of Jan. 1: \$ □ Position □ Hours worked per week: □ Position □ Hours worked per week: □ Hours worked per year: □ Life Insurance □ Life Insurance □ Long-Term Disability □ Lealth Insurance: □ Single □ E+1 □ Family □ Dental Insurance: □ PreventivePlus □ Humana PPO □ Traditional Preferred □ DEE □ DEE+CH □ DEE+SP □ Family □ Short-Term Disability □ Lealth Care Spending Account \$ □ Dependent Care Spending Account \$ □ Term Disability □ Dependent Care Spending Account \$ □ Term Disability □ Dependent Care Spending Account \$ □ Term Disability □ Date Benefit Change Effective: □ New Salary \$ □ Date Change Effective: □ Date Date Date □ Date Date Date □ Date Date Date Date Date Date Date Date	EMPLOYEE DATA:						
□ Street Address □ City/State/Zip □ Work □ City/State/Zip □ Work □ Coty/State/Zip □ More □ Annual Salary as of Jan. 1: \$ □ Position □ Hours worked per week: □ Position □ Hours worked per week: □ Hours worked per year: □ Life Insurance □ Life Insurance □ Long-Term Disability □ Lealth Insurance: □ Single □ E+1 □ Family □ Dental Insurance: □ PreventivePlus □ Humana PPO □ Traditional Preferred □ DEE □ DEE+CH □ DEE+SP □ Family □ Short-Term Disability □ Lealth Care Spending Account \$ □ Dependent Care Spending Account \$ □ Term Disability □ Dependent Care Spending Account \$ □ Term Disability □ Dependent Care Spending Account \$ □ Term Disability □ Date Benefit Change Effective: □ New Salary \$ □ Date Change Effective: □ Date Date Date □ Date Date Date □ Date Date Date Date Date Date Date Date	☐ Employee Name						
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☐ Phone: Home Work ☐ Social Security Number Annual Salary as of Jan. 1: \$							
Social Security Number Annual Salary as of Jan. 1: \$							
Position							
Employee Benefit Plans Affected: Weeks worked per year:	Position			Hours worked per week:			
Life Insurance							
Long-Term Disability							
Health Insurance:					o monnou po		
Dental Insurance:	_	□Single	□E+1		□Family		
Short-Term Disability Dependent Care Spending Account \$ Dependent Care Spending Account \$ Dependent Care Spending Account \$ The change affects Flexible Spending Accounts, a copy of this form must be sent to AIM. REASON FOR BENEFIT CHANGE:		_			-	□Traditional Preferred	
Short-Term Disability Health Care Spending Account \$ Dependent Care Spending Account \$ **If change affects Flexible Spending Accounts, a copy of this form must be sent to AIM. REASON FOR BENEFIT CHANGE:							
Health Care Spending Account \$ Dependent Care Spending Account \$ **If change affects Flexible Spending Accounts, a copy of this form must be sent to AIM. REASON FOR BENEFIT CHANGE:			J .	0.	⊡. u.i.i.y		
**If change affects Flexible Spending Accounts, a copy of this form must be sent to AIM. REASON FOR BENEFIT CHANGE: TERMINATION DATE:	_		п	Depe	ndent Care	Spending Account \$	
REASON FOR BENEFIT CHANGE: TERMINATION DATE: Date Benefit Change Effective: Reason for Termination: Date Benefit Change Effective: AND elects coverage TRANSFER DATE: Date Benefit Change Effective: From Parish/Organization Subgroup #: New Salary \$ Date Benefit STATUS CHANGE: Number of Hours Worked Weekly From To Date Change Effective: New Salary \$ Date	•	-		-			
RETIREMENT DATE:	☐ TERMINATION DATE:				_		
AND elects coverage TRANSFER DATE: Date Benefit Change Effective: From Parish/Organization Subgroup #: New Salary \$ To Parish/Organization Subgroup #: New Salary \$ BENEFIT STATUS CHANGE: To Date Change Effective: New Salary \$ Date Change Effective: New Salary \$ Employee Signature Date	Reason for Termination:_						
From Parish/Organization Subgroup #: New Salary \$ To Parish/Organization Subgroup #: New Salary \$ BENEFIT STATUS CHANGE: Number of Hours Worked Weekly From To Date Change Effective: New Salary \$ Other: Employee Signature Date	☐ RETIREMENT DATE:						
From Parish/Organization Subgroup #: New Salary \$ To Parish/Organization Subgroup #: New Salary \$ BENEFIT STATUS CHANGE: Number of Hours Worked Weekly From To Date Change Effective: New Salary \$ Other: Employee Signature Date	☐ TRANSFER DATE:		Date Benefit Change Effective:				
BENEFIT STATUS CHANGE: Number of Hours Worked Weekly FromTo Date Change Effective: New Salary \$ Other: Employee SignatureDate	From Parish/Organization		Subgroup #:				
□ Number of Hours Worked Weekly FromTo Date Change Effective: New Salary \$ Other: Employee Signature Date	To Parish/Organization		Subgroup #: New Salary \$			New Salary \$	
□ Number of Hours Worked Weekly FromTo Date Change Effective: New Salary \$ Other: Employee Signature Date	T DENEELT STATUS CHANGE						
Date Change Effective: New Salary \$ Other: Employee Signature Date			1	To			
Other: Employee Signature	-						
		- 3				, -	
	Employee Signature			Date			
	Bookkeeper/Administrator						