ARCHDIOCESE OF LOUISVILLE
NOTIFICATION OF EMPLOYEE BENEFIT CHANGE

PARISH/ORGANIZATION________________________________ **Group #** _________________

****SEND COMPLETED FORM TO PERSONNEL OFFICE****

☑ Check Items to Change

EMPLOYEE DATA:

❐ **Employee Name**____

❐ **Street Address**____

❐ **City/State/Zip**____

❐ **Phone: Home**___________________**Work**___________________________

❐ **Social Security Number**______________________ **Annual Salary as of Jan. 1: $**_________

Position___________________________________ **Hours worked per week:**____________

Employee Benefit Plans Affected: **Weeks worked per year:**____________

❐ **Life Insurance** **Hours worked per year:**____________

❐ **Long-Term Disability**

❐ **Health Insurance:** ❐**Single** ❐**E+1** ❐**Family**

❐ **Dental Insurance:** ❐**PreventivePlus** ❐**Humana PPO** ❐**Traditional Preferred**

❐**EE** ❐**EE+CH** ❐**EE+SP** ❐**Family**

❐ **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:

❐ **TERMINATION DATE:**_______________ **Date Benefit Change Effective:**_____________

Reason for Termination:____

❐ **RETIREMENT DATE:**___________________ ❐ **Meets eligibility for Group 180, Early Retirees, AND elects coverage**

❐ **TRANSFER DATE:**_______________________ **Date Benefit Change Effective:**_____________

From Parish/Organization______________ **Subgroup #:**_______

To Parish/Organization________________ **Subgroup #:**_______ **New Salary $**____________

❐ **BENEFIT STATUS CHANGE:**

❐ **Number of Hours Worked Weekly From**________**To**________

Date Change Effective:_____________ **New Salary $**________________

❐ **Other:** ____

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Employee Signature____________________________________**Date**________________

Bookkeeper/Administrator______________________________ **Date**________________

Revised 01/01/2015 Notification of Benefit Change Form.xls