

**ARCHDIOCESE OF LOUISVILLE
NOTIFICATION OF EMPLOYEE BENEFIT CHANGE**

PARISH/ORGANIZATION _____
PARISH Subgroup # _____

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|--|
| FOR ACCOUNTING USE ONLY DATE REC'D: _____ |
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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: _____
- Hours worked per year: _____
- Life Insurance
- Long-Term Disability
- Health Insurance: Single E+1 Family
- Humana 500
- Coverage First
- Dental Insurance: EE EE+CH EE+SP Family
- PreventivePlus
- Humana PPO
- Traditional Preferred
- Short-Term Disability
- Cash Option: \$50 \$100
- * Health Care Spending Account \$ _____ Dependent Care Spending Account \$ _____

REASON FOR BENEFIT CHANGE:

- TERMINATION DATE: _____ Date Benefit Change Effective: _____
Reason for Termination: _____
- TRANSFER DATE: _____ Date Benefit Change Effective: _____
From Parish/Organization _____ Subgroup #: _____
To Parish/Organization _____ Subgroup #: _____
- BENEFIT STATUS CHANGE:
 No. of Hours Worked From _____ To _____
 Other: _____

Employee Signature _____ Date _____

Bookkeeper/Administrator _____ Date _____

*Copy of this form must be sent to both the Personnel Office and AIM (Flexible Spending Accounts.).