ARCHDIOCESE OF LOUISVILLE
NOTIFICATION OF EMPLOYEE BENEFIT CHANGE

PARISH/ORGANIZATION_____ **Division #** _____

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

☑ **Check Items to Change**

EMPLOYEE DATA:

❒ **Employee Name**_____

❒ **Street Address**_____

❒ **City/State/Zip**_____

❒ **Phone: Cell** _____ **Home** _____

❒ **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**
- ❒ **Dental Insurance:** ❒**PreventivePlus** ❒**Humana PPO** ❒**Traditional Preferred**
  ❒**EE** ❒**EE+Child(ren)** ❒**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:**_____
(last day worked or last date of contract) **(last day of the month)**

Reason for Termination:_____

❒ **RETIREMENT DATE:**_____ ❒ **Meets eligibility for Group 180, Early Retirees, AND elects coverage**

❒ **TRANSFER DATE:**_____ **Date Benefit Change Effective:**_____

From Parish/Organization_____ **Division #:**_____

To Parish/Organization_____ **Division #:**_____ **New Salary $**_____

❒ **BENEFIT STATUS CHANGE:**

- ❒ **Number of Hours Worked Weekly From**_____**To**_____

  Date Change Effective:_____ **New Salary $**_____

- ❒ **Other:** _____

Employee Signature_____**Date**_____

Bookkeeper/Administrator_____ **Date**_____