

Archdiocese of Louisville / Humana Employee Change Form
Employee Information and Changes

Last name _____ First name _____ MI ____ Social Security number _____

Parish/Organization _____ Group Number _____

Qualifying Event Information

Qualifying event date: ___ / ___ / _____

Reason for change:

- Re-hire
- Dependent birth/adopt
- Dependent child turns 26
- Marriage
- Legal separation
- Spouse deceased
- Spouse terminates employment
- Spouse's employer terminates coverage
- Spouse changes from full-time to part-time employment

Change Address Information

Address change applies to: Employee only Employee and all covered dependents

Only for the following dependent (please print full name): Last _____ First _____ MI _____

New street address _____

City _____ State _____ Zip code _____ County _____

Email address _____ Phone number _____

Dependent Changes

Please complete this section for all dependent changes.

1 Last name _____ First name _____ MI _____ Date of birth ___/___/_____

Gender: Female Male Relationship: Spouse Child Other: _____

Add or **Delete** dependent to/from my current plan for the following products: Medical Dental Vision

2 Last name _____ First name _____ MI _____ Date of birth ___/___/_____

Gender: Female Male Relationship: Spouse Child Other: _____

Add or **Delete** dependent to/from my current plan for the following products: Medical Dental Vision

3 Last name _____ First name _____ MI _____ Date of birth ___/___/_____

Gender: Female Male Relationship: Spouse Child Other: _____

Add or **Delete** dependent to/from my current plan for the following products: Medical Dental Vision

4 Last name _____ First name _____ MI _____ Date of birth ___/___/_____

Gender: Female Male Relationship: Spouse Child Other: _____

Add or **Delete** dependent to/from my current plan for the following products: Medical Dental Vision

Employee signature: _____ Date: _____

****Attach to Archdiocese of Louisville Notification of Employee Benefit Change Form****