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

	First Name	MI	_ Social Security Number	
sh/Organization			Group Number	
Qualifying Event Information				
ualifying event date: /	_/			
eason for change:				
O Re-hire				
 Dependent birth/adopt 				
O Dependent child turns 26				
O Marriage				
 Legal separation 				
 Spouse deceased 				
 Spouse terminates employn 				
 Spouse's employer terminat 	_			
• Spouse changes from full-tir	me to part-time employment			
Change Address Information				
ddress change applies to: O Emp	plovee only Q Emplovee and all	covered depe	endents	
• Only for the following dependent			First	MI
New street address				
City	State	Zip Code	County	
			County	
mail Address		-	Number	
Dependent Changes lease complete this section for all depen		-	Number	_
Dependent Changes Please complete this section for all dependent		Phone	-	_//
Dependent Changes lease complete this section for all depen	<i>dent changes.</i> First Name	Phone	Number VI Date of Birth	
Dependent Changes Dependent Changes Dease complete this section for all depen Last Name Gender: O Female O Male	dent changes. First Name SSN: / /	Phone N	Number MI Date of Birth ationship: O Spouse O Chi	ld 🔾 Other:
Dependent Changes Dependent Changes Description for all dependent Last Name Gender: > Female > Male D Add or > Delete dependent	dent changes. First Name SSN: / /	Phone N Rela owing produc	Number MI Date of Birth ationship: O Spouse O Chi cts: O Medical O Dental	ld O Other: O Vision
Dependent Changes Please complete this section for all dependent Last Name Gender: > Female > Male D Add or > Delete dependent to/	dent changes. First Name SSN: / / / from my current plan for the foll First Name	Phone Phone N Phone	Number MI Date of Birth ationship: O Spouse O Chi cts: O Medical O Dental	Id O Other: O Vision
Dependent Changes Dependent Changes Description for all dependent control of the section for all dependent to for all de	dent changes. First Name SSN: / / from my current plan for the foll First Name SSN: / /	Phone Phone Rela owing produc N 	Number MI Date of Birth ationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Ch	Id O Other: O Vision _// _// ild O Other:
Dependent Changes Dease complete this section for all dependent Last Name Gender: > Female Add or Delete dependent to/ Last Name Gender: > Female Add or Delete dependent to/ Last Name Gender: > Female Add or Delete dependent to/	dent changes. First Name SSN: / / from my current plan for the foll First Name SSN: / /	Phone Phone N Phone N Phone N Phone N Phone N Phone Phone N Phone	Number MI Date of Birth ationship: O Spouse O Chi its: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi ts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi ts: O Medical O Dental	Id O Other: Vision /// ild O Other: Vision
Dependent Changes Please complete this section for all dependent Last Name Gender: Female Add Or Delete dependent Last Name Gender: Female Male D Add O Delete D Add Jast Name Gender: Female Male D Add D Delete D Delete <t< td=""><td>first Name SSN: / / First Name First Name SSN: / / First Name SSN: / / First Name First Name First Name</td><td>Phone Phone N Phone N Phone N Phone N Phone N Phone Ph</td><td>Number MI Date of Birth ationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi ts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi ts: O Medical O Dental Date of Dental</td><td>Id O Other: O Vision _// ild O Other: O Vision _//</td></t<>	first Name SSN: / / First Name First Name SSN: / / First Name SSN: / / First Name First Name First Name	Phone Phone N Phone N Phone N Phone N Phone N Phone Ph	Number MI Date of Birth ationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi ts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi ts: O Medical O Dental Date of Dental	Id O Other: O Vision _// ild O Other: O Vision _//
Dependent Changes Dease complete this section for all dependent Last Name Gender: > Female Add or Delete dependent to/ Last Name Gender: > Female Add or Delete dependent to/ Last Name Gender: > Female O Add O Delete Dependent > Male O Add O Delete D Add O Delete	Ident changes. First Name SSN:/ / from my current plan for the foll First Name SSN:// from my current plan for the foll First Name SSN:// First Name SSN:// First Name SSN:/ First Name SSN:	Phone Phone N Phone Phon	Number VI Date of Birth ationship: O Spouse O Chi cts: O Medical O Dental VI Date of Birth lationship: O Spouse O Chi ts: O Medical O Dental VI Date of Birth lationship: O Spouse O Chi ts: O Medical O Dental VI Date of Birth lationship: O Spouse O Chi vii Date of Birth lationship: O Spouse O Chi	Id O Other: O Vision _// ild O Other: O Vision _// ild O Other:
Dependent Changes Description Description </td <td>Ident changes. First Name SSN:/ / from my current plan for the foll First Name SSN:// from my current plan for the foll First Name SSN:// First Name SSN:// First Name SSN:/ First Name SSN:</td> <td>Phone Phone Phone N Phone Phon</td> <td>Number MI Date of Birth ationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental</td> <td>Id O Other: O Vision _// / ild O Other: O Vision _// / </td>	Ident changes. First Name SSN:/ / from my current plan for the foll First Name SSN:// from my current plan for the foll First Name SSN:// First Name SSN:// First Name SSN:/ First Name SSN:	Phone Phone Phone N Phone Phon	Number MI Date of Birth ationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental	Id O Other: O Vision _// / ild O Other: O Vision _// /
Dependent Changes Please complete this section for all dependent Last Name Gender: O Female O Male O Add or O Delete dependent to/ Last Name Gender: O Female O Male O Add or O Delete dependent to/ Last Name Gender: O Female O Male O Add or O Delete dependent to/ Last Name Gender: O Female O Male O Add or O Delete dependent to/ Last Name Gender: O Female O Male D Add or O Delete dependent to/	first Name SSN: / / First Name SSN: / / First Name SSN: / / from my current plan for the foll First Name SSN: / / from my current plan for the foll First Name SSN: / / First Name	Phone Phone N Phone N Phone N Phone N Phone N Phone Phone N Phone	Number MI Date of Birth ationship: O Spouse O Chi ationship: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi ts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi ts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi ts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi ts: O Medical O Dental	Id O Other: O Vision _// ild O Other: O Vision _// ild O Other: O Vision _// ild O Other: O Vision _// /
Dependent Changes Please complete this section for all dependent Last Name Gender: O Female O Male D Add or O Delete dependent to/ Last Name Gender: O Female O Male D Add or O Delete dependent to/ Last Name Gender: O Female O Male D Add or O Delete dependent to/ Last Name Gender: O Female O Male D Add or O Delete dependent to/ Last Name Gender: O Female O Male D Add or O Delete dependent to/ Last Name Gender: O Female O Male D Add or O Delete dependent to/	Ident changes. First Name SSN:// from my current plan for the foll First Name SSN:// from my current plan for the foll First Name SSN:// from my current plan for the foll First Name SSN:// from my current plan for the foll First Name SSN:/	Phone	Number MI Date of Birth ationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth elationship: O Spouse O Chi	Id O Other: O Vision _// ild O Other: O Vision _// iild O Other:
Dependent Changes Please complete this section for all dependent Last Name Gender: O Female O Male D Add or O Delete dependent to/ Last Name Gender: O Female O Male D Add or O Delete dependent to/ Last Name Gender: O Female O Male D Add or O Delete dependent to/ Last Name Gender: O Female O Male D Add or O Delete dependent to/ Last Name Gender: O Female O Male D Add or O Delete dependent to/ Last Name Gender: O Female O Male D Add or O Delete dependent to/	Ident changes. First Name SSN:// from my current plan for the foll First Name SSN:// from my current plan for the foll First Name SSN:// from my current plan for the foll First Name SSN:// from my current plan for the foll First Name SSN:/	Phone	Number MI Date of Birth ationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth elationship: O Spouse O Chi	Id O Other: O Vision _// ild O Other: O Vision _// iild O Other:
Dependent Changes Please complete this section for all dependent Last Name Gender: O Female O Male O Add or O Delete dependent to/ Last Name Gender: O Female O Male O Add or O Delete dependent to/ Last Name Gender: O Female O Male O Add or O Delete dependent to/ Last Name Gender: O Female O Male O Add or O Delete dependent to/ Last Name Gender: O Female O Male D Add or O Delete dependent to/	Ident changes. First Name SSN:// from my current plan for the foll First Name SSN:// from my current plan for the foll First Name SSN:// from my current plan for the foll First Name SSN:// from my current plan for the foll First Name SSN:/	Phone	Number MI Date of Birth ationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth lationship: O Spouse O Chi cts: O Medical O Dental MI Date of Birth elationship: O Spouse O Chi	Id O Other: O Vision _// ild O Other: O Vision _// iild O Other:

Attach to Archdiocese of Louisville Notification of Employee Benefit Change Form