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 SSN: __ __ __ / __ __ / __ __ __ __ 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 SSN: __ __ __ / __ __ / __ __ __ __ 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 SSN: __ __ __ / __ __ / __ __ __ __ 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 SSN: __ __ __ / __ __ / __ __ __ __ Relationship: ❍ Spouse ❍ Child ❍ Other: _____

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

Employee Signature: _____ Date: _____

Revised 05/08/2019 ****Attach to Archdiocese of Louisville Notification of Employee Benefit Change Form****