ARCHDIOCESE OF LOUISVILLE
NOTIFICATION OF EMPLOYEE BENEFIT CHANGE

PARISH/GROUP NAME:_____ Group # _____

SEND COMPLETED FORM TO PERSONNEL OFFICE Fax: 502-585-2466

EMPLOYEE DATA:

Employee Last_____First _____MI_____
Street Address_____
City/State/Zip_____
Phone: Home_____Work_____
Date of Birth_____
Social Security Number_____ Annual Salary as of Jan. 1: $_____
Position_____ Hours worked per week:_____
Weeks worked per year:_____ Hours worked per year:_____

Current Employee Benefit Plans:

- ❒ Life Insurance/ Long-Term Disability
- ❒ Health Insurance: □Single □E+1 □Family
- ❒ Dental Insurance:
  - ❒ Preventive Plus□PPO □Traditional Preferred
  - ❒ EE □EE+C □EE+SP □Family
- ❒ Vision: □Single □E+1 □Family
- ❒ Short-Term Disability
- ❒ Health Care Spending Account $_____
- ❒ Dependent Care Spending Account $_____
- ❒ Reliance Standard Supplemental Life

**If change affects Flexible Spending Accounts a copy of this form must be sent to AIM.

New Employee Benefit Plans:

- ❒ Life Insurance / Long-Term Disability
- ❒ Health Insurance: □Single □E+1 □Family
- ❒ Dental Insurance:
  - ❒ Preventive Plus □PPO □Traditional Preferred
  - ❒ EE □EE+C □EE+SP □Family
- ❒ Vision Insurance: □Single □E+1 □Family
- ❒ Short-Term Disability
- ❒ Health Care Spending Account $_____
- ❒ Dependent Care Spending Account $_____
- ❒ Reliance Standard Supplemental Life

Qualifying Event Reason: _____
_____
Qualifying Event Date: _____

**If change affects Flexible Spending Accounts a copy of this form must be sent to AIM.

Attach applicable Humana enrollment/change forms and proof of gain/loss of coverage

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EMPLOYEE TERMINATION:

❒ TERMINATION DATE:_____ Date Benefit Change Effective:_____
(last day of the month)

Reason for Termination:_____
Personal E-mail: _____

❒ RETIREMENT DATE:_____ □Meets eligibility for Group 180, Early Retirees, AND elects coverage
**Contact Personnel Office for Early Retiree Enrollment Form

EMPLOYEE TRANSFER:

❒ TRANSFER DATE:_____ Date Benefit Change Effective:_____
From Group #:_____ To Group #: _____New Salary $_____
Attach applicable Humana enrollment/change forms

EMPLOYEE STATUS CHANGE:
Number of Hours Worked Weekly From_____To_____Date Change Eff:_____ New Salary $_____
□Other: (Explain)

Employee Signature_____Date_____

Bookkeeper/Administrator_____ Date_____

Revised 6/4/2020