ARCHDIOCESE OF LOUISVILLE
NOTIFICATION OF EMPLOYEE TERMINATION FORM

PARISH/GROUP NAME: _____ Group #: _____

SEND COMPLETED FORM TO HUMAN RESOURCES OFFICE Fax: 502-585-2466

EMPLOYEE DATA:

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

Employee Benefits to Terminate:

- ❒ Life Insurance/ Long-Term Disability
- ❒ Health:
  - ❒ Employee only
  - ❒ Employee + Spouse
  - ❒ Employee + Child(ren)
  - ❒ Family
- ❒ Dental: (Choose plan)
  - ❒ Preventive Plus
  - ❒ PPO
  - ❒ Traditional Preferred

(Choose level of coverage)

- ❒ Employee only
- ❒ Employee +Spouse
- ❒ Employee + Child(ren)
- ❒ Family

Employee Benefits to Terminate (cont):

- ❒ Vision:
  - ❒ Employee only
  - ❒ Employee + Spouse
  - ❒ Employee + Child(ren)
  - ❒ 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.

EMPLOYEE TERMINATION:

❒ TERMINATION DATE: _____ Date Benefits End: _____ (last day of the month)

Reason for Termination: _____

Personal E-mail: _____

❒ * RETIREMENT DATE: _____ ☐Meets eligibility for Group 180 - Early Retirees & elects' coverage

*Contact Human Resources Office for Early Retiree Enrollment Form

---

Employee Signature _____Date_____

Bookkeeper/Administrator_____ Date_____

CB: _____
L: _____
E: _____
BP: ____

Revised 10/13/2023