

ARCHDIOCESE OF LOUISVILLE
NOTIFICATION OF EMPLOYEE BENEFIT CHANGE

PARISH/GROUP NAME: _____ Group #: _____

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

EMPLOYEE DATA:

☐ Check here if address change only

Employee: First _____ MI _____ Last _____

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: _____

Current Employee Benefit Plans:

- ☐ Life Insurance/ Long-Term Disability
- ☐ Health:
 - ☐ Employee only
 - ☐ Employee + Spouse
 - ☐ Employee + Child(ren)
 - ☐ Family
- ☐ Dental: (Choose one plan)
 - ☐ Preventive Plus
 - ☐ PPO
 - ☐ Traditional Preferred(Choose one level of coverage)
 - ☐ Employee only
 - ☐ Employee + Spouse
 - ☐ Employee + Child(ren)
 - ☐ Family
- ☐ Vision:
 - ☐ Employee only
 - ☐ Employee + Spouse
 - ☐ Employee + Child(ren)
 - ☐ Family
- ☐ Short-Term Disability
- ☐ ** Health Care Spending Account \$ _____
- ☐ ** Dependent Care Spending Account \$ _____
- ☐ Reliance Standard Supplemental Life

New Employee Benefit Plans:

- ☐ Life Insurance/ Long-Term Disability
- ☐ Health:
 - ☐ Employee only
 - ☐ Employee + Spouse
 - ☐ Employee + Child(ren)
 - ☐ Family
- ☐ Dental: (Choose one plan)
 - ☐ Preventive Plus
 - ☐ PPO
 - ☐ Traditional Preferred(Choose one level of coverage)
 - ☐ Employee only
 - ☐ Employee + Spouse
 - ☐ Employee + Child(ren)
 - ☐ Family
- ☐ 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.**

Qualifying Reason: _____

Qualifying Event Date: _____

Attach benefit vendor enrollment/change forms and proof of gain/loss of coverage if applicable

EMPLOYEE TRANSFER:

- ☐ TRANSFER DATE: _____ Date Benefit Change Effective at new location: _____
From Group Name: _____ Group #: _____
To Group Name: _____ Group #: _____
New Salary \$ _____

EMPLOYEE STATUS CHANGE:

Number of Hours Worked Weekly From: _____ To _____ Date Change Eff: _____ New Salary \$ _____

Other: (Explain) _____

Employee Signature _____ Date _____

Bookkeeper/Administrator _____ Date _____

CBS: _____
L: _____
BP: _____