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:

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: ____

Revised 1/11/2024