

**ARCHDIOCESE OF LOUISVILLE  
NOTIFICATION OF EMPLOYEE BENEFIT CHANGE**

PARISH/ORGANIZATION \_\_\_\_\_  
PARISH Subgroup # \_\_\_\_\_

**FOR ACCOUNTING USE ONLY**  
DATE REC'D: \_\_\_\_\_

Check Items to Change

**EMPLOYEE DATA:**

- Employee Name \_\_\_\_\_
- Street Address \_\_\_\_\_
- City/State/Zip \_\_\_\_\_
- Phone: Home \_\_\_\_\_ Work \_\_\_\_\_
- Social Security Number \_\_\_\_\_ Annual Salary as of Jan. 1: \$ \_\_\_\_\_
- Position \_\_\_\_\_ Hours worked per week: \_\_\_\_\_
- Employee Benefit Plans Affected: Weeks worked per year: \_\_\_\_\_
- Hours worked per year: \_\_\_\_\_
- Life Insurance
- Long-Term Disability
- Health Insurance:     Single         E+1         Family
- Humana 500
- Coverage First
- Dental Insurance:     EE         EE+CH     EE+SP     Family
- PreventivePlus
- Humana PPO
- Traditional Preferred
- Short-Term Disability
- Cash Option:         \$60         \$125
- \*  Health Care Spending Account \$ \_\_\_\_\_  Dependent Care Spending Account \$ \_\_\_\_\_

**REASON FOR BENEFIT CHANGE:**

- TERMINATION DATE:** \_\_\_\_\_        **Date Benefit Change Effective:** \_\_\_\_\_  
Reason for Termination: \_\_\_\_\_
- TRANSFER DATE:** \_\_\_\_\_        **Date Benefit Change Effective:** \_\_\_\_\_  
From Parish/Organization \_\_\_\_\_ Subgroup #: \_\_\_\_\_  
To Parish/Organization \_\_\_\_\_ Subgroup #: \_\_\_\_\_
- BENEFIT STATUS CHANGE:**
- No. of Hours Worked From \_\_\_\_\_ To \_\_\_\_\_
- Other: \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_  
Bookkeeper/Administrator \_\_\_\_\_ Date \_\_\_\_\_

\*Copy of this form must be sent to both the Personnel Office and AIM (Flexible Spending Accounts.).