CATHOLIC DIOCESE OF COLUMBUS

Personal Information Change and Beneficiary Form

Please notify us for any changes in your personal information by completing this form and returning it to the Office of Insurance.

Employee's Full Name

Previous Name (If a name change occurred)

Address:

City State Zip Code

Home Phone Number: Cell Phone Number:

Person to Notify in Case of Emergency:

Full Name:

Phone:

BENEFICIARIES: Lincoln Financial Group Employee Life Insurance

$50,000 face value policy | 100% employer paid — Diocese of Columbus, OH

Name	Relationship	SSN	DOB	Benefit %	Primary
					Primary
					Primary
					Primary
					Secondary
					Secondary
					Secondary
					Secondary

BENEFICIARIES: Voluntary Employee Life Insurance Policy

Name	Relationship	SSN	DOB	Benefit %	Primary
					Primary
					Primary
					Primary
					Secondary
					Secondary
					Secondary
					Secondary

BENEFICIARIES: Spousal Life Insurance Policy

Name	Relationship	SSN	DOB	Benefit %	Primary
					Primary
					Primary
					Primary
					Secondary
					Secondary
					Secondary
					Secondary

BENEFICIARIES: Dependent Life Insurance Policy

Name	Relationship	SSN	DOB	Benefit %	Primary
					Primary
					Primary
					Primary
					Secondary
					Secondary
					Secondary
					Secondary

Employee Signature: _____

Date: _____

Please scan and email this signed and dated form to:
Catholic Diocese of Columbus
Attention; Insurance Office
tdepassio@columbuscatholic.org