CATHOLIC DIOCESE OF COLUMBUS
STATUS CHANGE - FROM FULL TIME TO PART TIME

Name: _____ Location: _____
(Last Name, First Name, Middle Initial

Home Address, City & Zip: _____

SS#: _____ Birth Date: _____ Marital Status: ____ Home Phone #: (___)-_____

Job Title: _____ Status Change Date: _____

Effective Date: _____ **Salary:** _____

Scheduled Hours per Week: _____Pay Frequency: _____ Status: _____

E-Mail Address: _____

Do you currently work or have you worked for another Diocesan location? Yes ___ No ___
If "Yes", name of location and dates of employment: _____

NOTE to Bookkeeper – you must update the Employee Type in HRP to a non-full-time type of: Employee Paid Benefit Eligible or ACA + Employee Paid Benefit. Please check with the Insurance Office to verify if Employee is eligible for Medical benefits based on prior service

Please indicate below the insurance coverage you wish to elect:

Medical Benefits (Base): _____ Employee _____Emp. + 1 _____ Family _____I decline
Medical Benefits (Enhanced): _____ Employee _____ Emp. + 1 _____Family _____I decline
(The premium is shared between the employee and the employer according to established annual rates)
Please verify if Employee will be eligible for Medical benefits based on prior service

Dental Benefits (Base): _____ Employee _____ Emp. + 1 _____ Family _____I decline
Dental Benefits (Enhanced): _____ Employee _____ Emp. + 1 _____ Family _____I decline
(The employee is responsible for 100% of the established annual premium)

Vision Benefits (Base): _____ Employee _____ Emp. + 1 _____ Family _____I decline
Vision Benefits (Enhanced): _____ Employee _____ Emp. + 1 _____ Family _____I decline
(The employee is responsible for 100% of the established annual premium)

If electing Employee + 1 or Family coverage for Health, Dental or Vision, please list your dependents below. Please note that dependents will **not** be covered without their social security number.

Name	Social Security #	Gender	Date of Birth

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Employee Life Insurance: Term Life & AD&D Buy-Up _____
(Up to 7 x Salary or $250,000, **(Amount)**
(whichever is less) without evidence of insurability
Employee Paid-Rate Based on Age of employee

List Beneficiaries:

Name	Relationship	SSN	DOB	Benefit %	
_____	_____	_____	_____	_____	Primary
_____	_____	_____	_____	_____	Primary
_____	_____	_____	_____	_____	Primary
_____	_____	_____	_____	_____	Primary
_____	_____	_____	_____	_____	Contingent
_____	_____	_____	_____	_____	Contingent
_____	_____	_____	_____	_____	Contingent
_____	_____	_____	_____	_____	Contingent

Spouse Life Insurance: Spouse Life & AD&D Buy-Up: _____
($5,000 increments up to $100,000 **(Amount)**
without evidence of insurability)
Limit 50% of employee election
Employee Paid–Rate Based on Age of employee

Dependent Child Life: Dependent Life & AD&D Buy-up _____
($25,000 - age over 6 months **(Amount)**
$1,000 – age under 6 months)
Employee Paid ($5.00)

By my signature below, I hereby authorize the Diocese of Columbus to deduct from my pay the established employee premium for the benefits I selected above. I understand these rates will remain in effect throughout the calendar year unless I experience a life-changing event or my employment is terminated with the Diocese of Columbus.

_____ _____

Employee Signature **Date**