DIOCESE OF ALLENTOWN

LAY EMPLOYEE DATABASE CHANGE FORM

Employee Name: _____ Social Security Number: _____

Location: _____ City: _____

Please check those that apply: **Form Completed by:**_____

☐ **Change in Employment Status:** Effective Date: _____

Full-Time _____ / No. of hours worked _____ Part-Time _____ / No. of hours worked _____

Termination _____ Resigned _____ Position Eliminated _____ Relocated _____ Retired _____ Death _____

If employee is being changed to full-time status, please complete the following:

1) Non-Pension Life Insurance Beneficiary Form Completed (Until eligible for pension plan)
2) Do you want health insurance coverage? Yes ____ No _____ Complete necessary application
   Single: _____ Family: _____

☐ **Transferring to another diocesan location:** Effective Date: _____

Name and address of new location: _____

_____

☐ **Change in Personal Status:** Effective Date: _____

Married_____ Separated_____ Divorced_____ Death of Spouse _____ Birth of Child _____

☐ **Adding** ☐ **Removing a Spouse/Dependent:** Effective Date: _____

Name : _____ SS#: _____ Date of Birth: _____

☐ **Adding Dental Coverage** Effective Date: _____
(after one year of continuous full-time employment)

Coverage: Single _____ Family _____

☐ **Change of Address:** _____ Effective Date: _____

_____ Telephone Number: (_____)_____

☐ **Updating Emergency Contact:**

Name: _____ Home Telephone: (_____)_____

Address: _____ Work Telephone: (_____)_____

_____ Cell: (_____)_____

RETURN TO HUMAN RESOURCES OFFICE
FAX 610-439-7693

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