Catholic Diocese of Sioux Falls
523 N Duluth Ave
Sioux Falls, SD 57104
FAX (605)988-3852

EMPLOYEE BENEFITS CHANGE FORM

Please submit changes as they occur, one form per employee. Return completed form to Diocesan Human Resources Office.

SECTION A: EMPLOYEE INFORMATION			
NAME (Last, First, MI):		SOCIAL SECURITY NUMBER:	
ADDRESS (Number, Street, Apt#):	CITY:	STATE:	ZIP:
EMAIL:		CELL PHONE:	

SECTION B: NAME CHANGE		
FROM:	TO:	EFFECTIVE DATE:
REASON FOR CHANGE:		VERIFIED WITH SS CARD: ☐ YES ☐ NO

SECTION C: ADDRESS CHANGE		
STREET ADDRESS:		EFFECTIVE DATE:
CITY:	STATE:	ZIP:

SECTION D: ADD DEPENDENT CHILD		
DEPENDENT NAME (First, MI, Last):	DEPENDENT SOCIAL SECURITY #:	DATE OF BIRTH:
Circle the correct response below as it pertains to the dependent child. Leave no question blank:		
GENDER: ☐ MALE ☐ FEMALE	MEDICARE ENROLLED: ☐ YES ☐ NO	SOC SEC DISABLED: ☐ YES ☐ NO
EVENT TYPE : ☐ BIRTH ☐ ADOPTION ☐ LOSS OF COVERAGE ☐ RESUMING FT STUDENT STATUS		
Will you, your spouse or your dependent keep other coverage in addition to this coverage? YES ☐ NO ☐		
If yes, list the name of person keeping other coverage:		
Other Insurance Carrier name and address:		

➡ Employee Signature: _____ Date: _____

Benefit Coordinator Signature: _____ Date: _____

Location Employed: _____ City: _____