

2025 Employee Change in Information Form



This form must be completed for **all employee changes**.
 The insurance company uses this information to produce the bill and provide insurance.
 Fax this form (or forms) to 916-442-6927 Attn: Benefits
OR mail it to: The Episcopal Diocese of Northern California
 Attn: Benefits
 2394 Fair Oaks Blvd.
 Sacramento, CA 95825

Congregations and Institutions will be liable for costs associated with insurance that is not correctly processed, canceled, or changed due to this form not being received within **30** days of the date of the Qualifying Event.

This is a fillable form. Click on the box you wish to edit. You may also print this form and complete it by hand.

Employee Information			
Congregation/ Institution Name: _____	Congregation/ Institution City: _____		
Employee Name Title: _____	Clergy/Lay: _____	<input type="checkbox"/> Clergy	<input type="checkbox"/> Lay
First Name: _____	Employee Address: _____		
Last Name: _____	City, State: _____		
Change Date: _____	Zip Code: _____		
Annual Salary: _____ <i>(Total compensation)</i>	Status: _____ Select the appropriate box:	<input type="checkbox"/> Exempt	<input type="checkbox"/> Non-Exempt
		<input type="checkbox"/> Salaried	<input type="checkbox"/> Hourly
Base Salary: _____ <i>(For clergy only)</i>	Qualifying Event: _____		
Cash Housing Allowance: _____ <i>(For clergy only)</i>	Qualifying Event Date: _____		
Hours per year: _____			

If changes are made for someone other than the employee, please complete the enrollee's information below:			
Enrollee Name: _____	Enrollee Sex: _____	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Enrollee Social Security #: _____	Enrollee Date of Birth: _____		
Relationship to Employee: _____	Qualifying Event: _____		

Check each plan to add	
<input type="checkbox"/>	Pension
<input type="checkbox"/>	Medical
<input type="checkbox"/>	Dental
<input type="checkbox"/>	Life/ADD
<input type="checkbox"/>	Supplemental Life
<input type="checkbox"/>	Spouse Supplemental Life
<input type="checkbox"/>	Long Term Disability
<input type="checkbox"/>	IRP (Short Term Disability - Lay only)

Check each plan to terminate	
<input type="checkbox"/>	Pension
<input type="checkbox"/>	Medical
<input type="checkbox"/>	Dental
<input type="checkbox"/>	Life/ADD
<input type="checkbox"/>	Supplemental Life
<input type="checkbox"/>	Spouse Supplemental Life
<input type="checkbox"/>	Long Term Disability
<input type="checkbox"/>	IRP (Short Term Disability - Lay only)

Signature	
Prepared by: _____ <i>(Printed Name)</i>	Preparer's Job Title: _____
Preparer's Signature: _____	Date: _____

For questions, or to submit this form, please email benefits@norcalepiscopal.org.