2026 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:	☐ Clergy ☐ Lay
First Name:		Employee Address:	
Last Name:		City, State:	
Change Date:		Zip Code:	
Annual Salary: ***(Total compensation)***		Status: Select the appropriate box:	☐ Exempt ☐ Non-Exempt ☐ Salaried ☐ Hourly
Base Salary: ***(For clergy only)***		Qualifying Event:	
Cash Housing Allowance: ***(For clergy only)***		Qualifying Event Date:	
Hours expected to work per year:			

If changes are made for someone other than the employee, please complete the enrollee's information below:

Enrollee Name:		Enrollee Sex:	Male ☐ Female ☐
Enrollee Social Security #:		Enrollee Date of Birth:	
Relationship to Employee:		Qualifying Event:	

Check each plan to **add**	
☐	Pension
☐	Medical
☐	Dental
☐	Life/ADD
☐	Supplemental Life
☐	Spouse Supplemental Life
☐	Long Term Disability
☐	IRP (Short Term Disability – Lay only)

Check each plan to **terminate**	
☐	Pension
☐	Medical
☐	Dental
☐	Life/ADD
☐	Supplemental Life
☐	Spouse Supplemental Life
☐	Long Term Disability
☐	IRP (Short Term Disability – Lay only)

Signature

Prepared by: _____ Preparer's Job Title: _____
(Printed Name)

Preparer's Signature: Date:

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