LUTHERAN CHURCH–CANADA
WORKER BENEFIT PLANS

Request for Change

Please complete section 1 and any section where there has been a change.

1. Personal Information

Title:	First Name (and Initial):	Last Name:
Previous Last Name (if applicable):		
Address:		
City:	Province:	Postal Code:
Home Phone: ( )	Work Phone: ( )	Certificate Number (if available): 5000 __ __ __ __ __
Email Address:		
Name & Address of Employer:		

2. Marital Status

Mark with an "X" :	Married	Widowed	Divorced	Legally Separated
Effective Date:				

If married, please provide spouse's information:

First Name (and Initial):	Last Name (if different from yours):
Spouse's Date of Birth (yyyy/mm/dd):	Indicate with an "X" if spouse is also employed by a Lutheran Church–Canada employer: ( )

3. Salary - reported as an annual figure

Benefits and premiums are affected by salary changes. Prompt reporting of salary changes is therefore advised.

Effective Date:	Number of Hours/Week (Indicate with an "X") 15 - less than 24 hrs/wk ( ) 24 - 40+ hrs/wk ( )			
Basic	Parsonage (30%)	Cash Housing	Cash Utility Allow.	Total Compensation

4. Add Dependent Children

Add a Dependent Child				
Name (Last, First):	M/F	Birth Date: (yyyy/mm/dd)	If adopted or stepchild	
			Status	Eff. Date

If your child is an overage dependent, please complete this section:

Name	Disabled	Student	Effective Date

5. Terminate Dependant

Name	Relationship	Reason for Termination	Effective Date

6. Termination / Transfer / Leave of Absence

Effective Date	Indicate with an "X"		
		Terminated	Reason:
		Transferred to:	
		Transferred to USA	
		Leave of Absence	Reason:

7. Signature of Representing Employer

The employment information entered on this form is current and correct to the best of our knowledge. We agree to obtain from the employee any portion of the cost for participating in the Worker Benefit Plans required from the employee according to provisions of the Worker Benefit Plans, and to remit such portion along with the portion required by us as the employer.

Signature:	Title:	Date:

8. Signature of Employee

I authorize my employer to make payroll deductions from my pay for my contributions towards the pension and benefits program in which I participate; such contribution to be forwarded to LCC Worker Benefit Plans on my behalf.

Signature:	Date:

RETURN COMPLETED FORM TO WORKER BENEFIT PLANS
c/o Ellement, 503 - 1780 Wellington Avenue, Winnipeg, MB, R3H 1B3