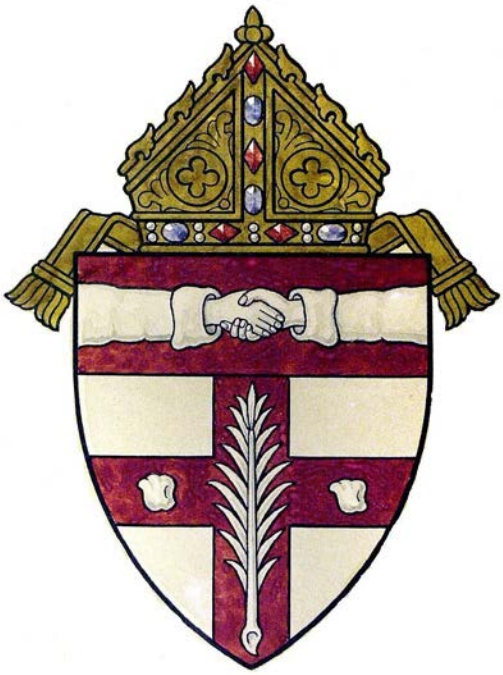
# *Diocese of Owensboro*

# *Employee Exit Packet*



**2023/2024**

Diocese of Owensboro

McRaith Catholic Center

# TERMINATION DOCUMENTATION FORM

| | | | |
|---|---|---|---|
| Employee Name: | | | |
| Location: | | | |
| Termination Date: | | Last Day Worked (If Different): | |
| Forwarding Address: | | | |

| REASON FOR SEPARATION | | |
|---|---|---|
| VOLUNTARY | ☐ Without Notice or Reason | ☐ Problem with Supervisor |
| | ☐ Another Job | ☐ Problem with Co-worker |
| | ☐ Relocation | ☐ Personal Problem |
| | ☐ Illness | ☐ Return to School |
| | ☐ Pay | ☐ Retirement |
| | ☐ Working Conditions | ☐ Refused Suitable Work |
| | ☐ Work Schedule | ☐ LOA - Did not return |
| | ☐ Enlisted in Armed Forces | ☐ Other |
| INVOLUNTARY | ☐ Absenteeism | ☐ Tardiness |
| | ☐ Insubordination | ☐ Unsatisfctory Performance |
| | ☐ Violation of Rules | ☐ Refusal to Follow Instruction |
| | ☐ Lack of Work | ☐ Job Eliminated or Changed |
| | ☐ Other | ☐ Involuntary Retirement |

| | | | |
|---|---|---|---|
| Explain the reason given above in detail: | | | |
| | | | |
| Employee's started reason for termintion: | | | |
| | | | |
| Is the employee eligible for rehire? | ☐ YES | ☐ NO | |
| If not elegible or only under certain conditions, explain: | | | |
| | | | |

| EXIT INTERVIEW | | | |
|---|---|---|---|
| ☐ Interviewed by: | | Date: | |
| | | | |
| ☐ Exit questionnaire and sypnosis reviewed and filed. | | Date: | |
| | | | |
| Follow-up required | ☐ YES | ☐ NO | |

| ITEMS RECEIVED FROM EMPLOYEE (ENTER N/A IF NOT APPLICABLE) | | |
|---|---|---|
| | Received by | Date |
| Keys | | |
| Keys fob | | |
| Laptop /Computer | | |
| Other | | |

| PAYROLL | | |
|---|---|---|
| | Date | |
| Final Paycheck | | |
| Vacation (# of hours _____ ) | | |
| Other | | |
| BENEFITS | | |
| ☐ Insurance Terminated | ☐ 403b Plan Terminated | ☐ Retirement Terminated |
| | | |
| ☐ Self Pay ppw give to employee | ☐ Self Insurance ppw give to employee | ☐ Other |
| | | |
| HR Signature: | Date: | |
| | | |
| Printed Name: | | |

# DIOCESE OF OWENSBORO
# SELF PAY - EMPLOYEE BENEFIT PLAN PREMIUM RATES
# RATES EFFECTIVE SEPTEMBER 1, 2023 to AUGUST 31, 2024

## Medical/Dental/Prescription Coverage

| | $1,000 Deductible | $3,500 Deductible |
|---|---|---|
| **Single** | **Monthly Rates** | **Monthly Rates** |
| Total Premium – Self Pay | **$1,081.00** | **$788.00** |
| | | |
| **Employee & Family** | | |
| Total Premium – Self Pay | **$1,892.00** | **$1,408.00** |

# Diocese of Owensboro
# Health Benefit Plan

***Self-Pay Privilege Notification Letter***

Date: _____
Participant Name: _____
Address: _____
_____

Dear _____:
Your current level of health/dental insurance sponsored by the Diocese of Owensboro will be terminated as of _____ due to _____ on _____. You are entitled, by a continuation provision of the insurance plan, to continue the current level of health/dental coverage in which you are currently enrolled for up to eighteen months or in the case of early retirement until you become eligible for Medicare. In order to maintain continuation coverage under the plan the following conditions must be met:

1. You must elect to continue coverage within 60 days from the date of this letter.
2. You must make your monthly payments in a timely manner.
3. Those under your current level of health/dental are not covered by any other health plan or entitled to Medicare benefits, provided that the other coverage does not contain an exclusion or limitation due to pre-existing limitations

You may be able to extend your continuation coverage from 18 to 29 months, if the Social Security Administration has determined (or determines) that you have been deemed totally disabled prior to or at any time during the first 60 days of continuation coverage. (You must submit a copy of the Social Security disability determination notice within 60 days of receiving the notice and before the end of the initial 19 months of continuation.)

The enclosed election form must be received by BAS, Inc. within 60 days of the date of this letter. Your first payment is due 45 days after you send in your election form and must include payment back to the loss of coverage date. Then all subsequent payments are due on the first of the month and the payment cannot be postmarked more than 30 days from the due date to be accepted. If your first payment, or any subsequent payment, is not received within this time frame, your continuation rights will be terminated. Coverage is provided only when the full payment for the applicable period is received. Please refer to the enclosed election form for the monthly premium amount due to continuation.

If you have any questions, please call Greg Pack at 800-446-8469.

# Diocese of Owensboro
## Self-Pay Privilege
## Continuation of Health Care Coverage Election Form

***Important:***
If you wish to continue your health coverage, BAS, Inc. must receive:

1. A completed copy of this election form within 60 days of the date of our initial notice to you;

***AND***

2. Your first payment 45 days following the date you return this election form.
   Your first payment will be for the period beginning on _____ through the end of the month in which you submit your payment. Subsequent monthly payments are due on the first day of each month.

Coverage is provided only when the full payment for the applicable period is received.

***Employee completes the following information:***

I wish to continue coverage under the Roman Catholic Diocese of Owensboro as follows: (each individual from whom coverage is to be continued must have been covered under the Roman Catholic Diocese of Owensboro's health plan on _____, immediately before the qualifying event.):

*Check one:*

___ 1. Single coverage (current monthly premium is $_____).

___ 2. Family coverage (current monthly premium is $_____).

Signature: _____ Date:_____

Print Name: _____ SSN#: _____

**Return this completed and signed form to:** BAS, Inc.
P.O. Box 896
Bluefield, WV 24701

BAS, Inc. will bill you directly for premiums. **Your payment should be made out to the Roman Catholic Diocese of Owensboro Health Plan** and mailed to: BAS, Inc.
P.O. Box 896
Bluefield, WV 24701

# YES! I want to keep my Colonial Life Coverage.

Colonial Life®

## My premiums are no longer being payroll-deducted.

*Complete this form and mail it today — along with a check for your premium payment.*

**Did you know that you can continue your coverage online at coloniallife.com? See below for information.**

Name: _____ Daytime Telephone Number: (____) _____

Mailing Address: _____ Social Security Number or Date of Birth:_____

City: _____ State: _____ Zip:_____

Policy number(s) to be continued:

_____, _____, _____, _____,

Which Colonial Life & Accident Insurance do you want to continue? (check one or more)

◯ Accident ◯ Disability ◯ Hospital Income ◯ Dental ◯ Cancer or Critical Illness ◯ Life

**Please choose one of the following payment options:**

☐ 1. Deduct premiums monthly from my bank account.

☐ 1st-5th ☐ 6th-10th ☐ 11th-15th ☐ 16th-20th ☐ 21st-26th

Your draft will occur on one of the dates within the range you have selected. Please include a voided check or

Routing #_____ and Account #_____

_____
Signature of bank account owner

☐ 2. Bill me directly. (choose one of the following)

☐ Quarterly (Submit a payment 3 times your monthly premium)

☐ Semi-annually (Submit a payment 6 times your monthly premium)

☐ Annually (Submit a payment 12 times your monthly premium)

Date:_____ Policy Owner's Signature:_____

Return To:

Colonial Life & Accident Insurance Company
P.O. Box 1365
Columbia, South Carolina 29202
1.800.325.4368 (phone)
1.800.561.3082 (fax)

OR

***Save time and postage by going to: coloniallife.com to elect electronically to continue your coverage by changing in the portal your payment method and epaying premium due.**

*Colonial Life products are underwritten by Colonial Life & Accident Insurance Company, for which Colonial Life is the marketing brand.*

# Extended Continuation Election
# Accident, Critical Illness, Hospital Indemnity

**You can continue your Accident, Critical Illness, and/or Hospital Indemnity coverage when you leave your employer.**

To keep your Accident, Critical Illness, and/or Hospital Indemnity coverage under extended continuation, fill out the attached application and return it to Anthem. We must receive your application within 31 days of your last day worked.

### How much will it cost?

You'll pay the same rate for Accident and/or Hospital Indemnity that you paid through payroll deduction with your employer.

You'll pay the same rate for Critical Illness that you paid through payroll deduction with your employer but the Critical Illness rate is based on your age. When you move into a new rate bracket due to your age, your rate will change.

Call us at 1-844-639-0947 to find out how much your monthly premium will be to continue your coverage.

You'll get a bill each month for your continued coverage. You need to mail a check for your full premium amount shown on the bill and the payment coupon to Anthem every month, to the address shown on the payment coupon. If we do not receive premium within 31 days from the due date, your coverage will end and cannot be reinstated.

### How long can I continue my coverage?

You can continue Critical Illness coverage and Accident coverage as long as your prior employer continues their Anthem plan, or until you reach age 85, whichever comes first. If your prior employer terminates their Anthem plan, your coverage ends when the Anthem plan ends.

You can continue your Hospital Indemnity coverage as long as your prior employer continues their Anthem plan, or until you reach age 85, or for three years, whichever comes first. If your prior employer terminates their Anthem plan, your coverage ends when the Anthem plan ends.

### Can I continue coverage for my covered family members?

You can only continue coverage for your family members who you cover under your plan only if you elect to extend your own coverage. Family members' coverage can't be continued without also continuing your own coverage.

### Your Certificate of Coverage

Keep the Certificate of Coverage your employer gave to you. The same Certificate of Coverage applies to your Extended Continuation coverage.

### How can I get more information?

If you have questions about this information or need help filing out the Extended Continuation form, call us at 1-844-639-0947.

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este document.

# Extended Continuation Election

Use this form to continue your coverage after your employment ends

**INSTRUCTIONS**

Read and complete all of this form. Please use 4 digits for years.

| **Section 1: You can obtain this information from your former employer** | | |
|---|---|---|
| Former Employer/Association/Union Name | Group No. | Subsection |

**Section 2: Elect your extended coverage**

I elect to continue my coverage for: ☐ Accident ☐ Critical Illness ☐ Hospital Indemnity

Extended coverage is at the same benefit level for you and your dependents as your active coverage.

**Section 3: Your Information**

| Last Name | First Name | M.I. | Date of Birth (MM/DD/YYYY) |
|---|---|---|---|
| | | | |

| Social Security No. | Phone No. | Email Address |
|---|---|---|
| | | |

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Date Employment Terminated (MM/DD/YYYY) | Check here if address or email address updated ☐ |
|---|---|
| | |

**Section 4: Premium Information and Payment**

1. To get the premium amount for your extended continuation coverage, call 1-844-639-0947.
2. Fill in your premium amount here: $_____
3. Mail this Extended Continuation Election form to:

   Anthem
   Special Operations Unit
   8940 Lyra Drive
   Suite 300
   Columbus, OH 43240

**Section 5: Authorization – read carefully before signing**

By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself. I certify the Social Security number listed on this application is correct.

I understand that no extended continuation coverage will be effective unless this Extended Continuation Election form and the full premium required have been submitted in accordance with the terms of the Group Policy. If not, any premium received will be refunded.

Extended continuation coverage will be effective on the first day following the termination of employment, provided that Anthem receives this completed Extended Continuation Election form within 31 calendar days after my coverage under the Group Policy would otherwise end.

For extended continuation coverage to remain in effect, I must continue to pay premiums by the first day of each month. Premiums are paid to the address shown on the payment coupon sent with the monthly bill. Extended continuation coverage will terminate if premium payments are not received within the 31 day grace period.

The terms of extended continuation coverage are set forth in the Certificate issued under the Group Policy. The amount of insurance in effect on the date my coverage would otherwise have ended will continue. No further increases to my benefit amount nor changes in amount of coverage will be allowed, nor will I be able to add any optional benefits.

The information on this form is true and complete to the best of my knowledge.

| Employee Signature<br>x | Date (MM/DD/YYYY) |
|---|---|
| | |

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este document.

**IMPORTANT ACCIDENT INSURANCE ELIGIBILITY INFORMATION:**
**The following notice applies to all Accident and Voluntary Accident coverage presented on this form:**
**ACCIDENT INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

**IMPORTANT CRITICAL ILLNESS INSURANCE ELIGIBILITY INFORMATION:**
**The following notice(s) apply to all Critical Illness and Voluntary Critical Illness coverage presented on this form:**
**CRITICAL ILLNESS INSURANCE IS A SUPPLMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

**IMPORTANT HOSPITAL INDEMNITY INSURANCE ELIGIBILITY INFORMATION:**
**The following notice applies to all Hospital Indemnity and Voluntary Hospital Indemnity coverage presented on this form:**
**HOSPITAL INDEMNITY INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

**The laws of some states require us to provide you with the following information**

**California:** For your protection California law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Maine, Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

**New Hampshire:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. §638:20.

**New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

**Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**General Fraud Warning:** Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be subject to criminal penalties.


# Life Insurance Portability and Conversion Forms

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

**Group Portability**
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (877) 466-8367

# A Guide for Successfully Completing the Mutual of Omaha Term Life Portability Request Form

Mutual of Omaha appreciates the opportunity to provide you with valuable life insurance protection for yourself and/or your loved ones. So that we can effectively process your request for life insurance under the Term Life Portability Plan, we rely on the information you provide on this form.

This guide provides information and instruction to help you successfully complete and submit the form. Please consult your employer/benefits administrator if you need assistance with information for the form.

## About the Form

The Term Life Enhanced Portability Form is a request for insurance under Mutual of Omaha's Term Life Portability Plan. Insurance under this plan is available to employees/members (hereafter referred to as "members") and/or eligible dependents when insurance under a Mutual of Omaha group term life insurance plan (voluntary and/or basic) offered by an employer/group ceases.

A completed and signed form with initial premium payment MUST be mailed to Mutual of Omaha within 31 days after insurance has ceased under the group plan for your request to be considered. All sections of the form are to be completed. Make sure you provide all required information and answer all questions completely and accurately. If information is missing or is illegible (unreadable), the processing of the form will be delayed. Please contact the employer/benefits administrator to determine or confirm information as needed.

Refer to the guidelines for each section below, which provide valuable information to help you successfully complete the form.

### Section 1: Employer/Group Information

Provide the name and ID number for the employer/group. The number will have eight characters, beginning with "G000" followed by four additional letters or numbers specific to the employer/group. The original date of hire or date of association for the member must also be provided.

### Section 2: Applicant Information

Please provide all required applicant information. If the Member is eligible to port insurance, the member must be the applicant and elect insurance for dependents to be eligible. If the member is not eligible to port insurance, the spouse (in the event of divorce or the employee's death, for example) can be the applicant and is eligible to port term life insurance for her/himself and dependents.

The applicant must be age 70* or less to be eligible for insurance. Insurance under the portability plan terminates at age 70*.

To ensure any additional correspondence regarding your request occurs as quickly as possible, check the box to consent to receive future correspondence via email.

### Section 3: Dependent Information

To be eligible to port term life insurance, dependents must have been insured under the group plan on the day preceding the day coverage ceased under the plan. If the member is eligible to port insurance, the member must elect insurance for dependents to be eligible.

### Section 3: Dependent Information (continued)

In addition, a spouse must be age 70* or less and children age 26* or less to be eligible for insurance. Spouse insurance under the portability plan terminates at age 70*, and child insurance terminates at age 26*.

If the applicant is a spouse, do not provide spouse information in this section.

### Section 4: Current Term Life Insurance Amount(s) Eligible For Portability

For the applicant and eligible dependents, provide the term life insurance amount(s) that were both:

- In-force at the time coverage ceased under the group plan; and
- Eligible for portability† (the contract for coverage contained a portability provision).

These are the maximum amount(s) of coverage that can be requested under the portability plan.

†You may have had group life insurance under a Voluntary Term Life Insurance plan, a Basic Life Insurance plan, or both, from the group. Any plan must include a portability provision for the insurance available to you under the plan to be portable. It may be possible that the insurance you had under a Voluntary Term Life Insurance plan is portable, but the insurance you had under a Basic Life Insurance plan is not, for example. Please consult the contract for each plan or the employer/benefits administrator to determine if portability is available.

IMPORTANT: If a living benefit payment has been received, portability continuation is not available.

## Section 5: Monthly Rates Per $1,000 of Insurance

These are the monthly rates per $1,000 of insurance that apply under the Term Life Portability Plan.

The member and spouse rates are age banded, which means that the premium for member and spouse insurance is assessed according to age – as the member or spouse age and advances to the next age band, premiums for insurance will increase accordingly. The initial premium payment is based on the current age of the member or spouse. The child rate does not vary by age.

If the term life insurance offered by the group included an accidental death & dismemberment (AD&D) insurance rider, you are also eligible to port AD&D insurance in an amount equal to the amount of life insurance ported, if you so choose. This rate is the same for member, spouse and child(ren) and does not vary by age.

The rates presented in Section 5 are used in Section 6 to determine premium for insurance under the portability plan.

## Section 6: Portability Insurance Election & Initial Premium Payment Calculation

To complete insurance election and initial premium payment calculation, the type of insurance requested must be indicated, then premium amounts must be calculated for each individual for whom ported insurance is being requested, and a billing mode must be selected.

First, select the type of insurance requested, either "Life Insurance Only" or "Life and AD&D Insurance." If the term life insurance offered by the group included an accidental death & dismemberment (AD&D) insurance rider, you are also eligible to port AD&D insurance in an amount equal to the amount of life insurance ported, if you so choose.

Next, do the following to complete this section:

(1) Provide the first name of each individual for whom ported insurance is being requested.

(2) Provide the Insurance Amount each individual is requesting (rounded up to the nearest $1,000), subject to the following:

- The Insurance Amount for each individual must be less than or equal to the amount of insurance the individual had when insurance ceased under the group plan, not to exceed $500,000. The maximum amounts are equivalent to the Current Insurance Amounts indicated in Section 4.
- The Insurance Amount for the employee must be $10,000 or more. The Insurance Amount for spouse must be $5,000 or more, and for child(ren), $2,000 or more.
- If the applicant is an employee, dependent spouse and child(ren) insurance amounts must be less than or equal to 50% of the insurance amount applied for by the member.
- Insurance Amount(s) must be in increments of $5,000 for the member and/or spouse. (Example: $10,000 and $25,000 are acceptable insurance amounts, but $12,000 and $27,000 are not.) The Insurance Amount for child(ren) must be in $1,000 increments.

(3) Calculate the Coverage Factor for each individual, by dividing your Insurance Amount (2) by 1,000. (Example: $25,000 / 1,000 = 25; 25 is the Coverage Factor.)

## Section 6: Portability Insurance Election & Initial Premium Payment Calculation (continued)

(4) Insert the appropriate monthly rate per $1,000 of insurance for each individual, for the current age for member and/or spouse. Rates are provided in Section 5. If you are requesting both life and AD&D insurance, you must add the AD&D monthly rate per $1,000 ($0.060) to the life monthly rate per $1,000 to obtain the appropriate monthly rate per $1,000. (Example: The appropriate monthly rate per $1,000 for a 34 year old applicant requesting life and AD&D coverage is $0.254 ($0.194 for Life plus $0.060 for AD&D).)

(5) Calculate the Monthly Premium for each individual, by multiplying the Coverage Factor (3) by the Monthly Rate (4).

(6) Calculate the Total Monthly Premium, by adding together all of the amounts in the Monthly Premium (5) column.

(7) Select a billing frequency. To pay premium every 3 months (quarterly), insert a "3" into column (7). To pay premium twice a year (semi-annually), insert a "6" into column (7). To pay premium annually, insert a "12" into column (7).

(8) Calculate the Initial Premium Payment, by multiplying the Total Monthly Premium (6) by the Billing Frequency (7).

## Section 7: Beneficiary For Death Benefits

You must designate a beneficiary for any life insurance proceeds in the event of your death. You (the applicant) are the beneficiary for any dependent life insurance.

If you wish to designate additional beneficiaries (beyond what space allows for on the form), please attach an additional sheet of paper to the form that includes the required information.

## Section 8: Acknowledgement and Signature

Read the statements in this section. If you understand and agree to the statements, sign and date the form to complete the form. Your signature binds you to the statements in this section, and allows the form to be processed by Mutual of Omaha.

## Section 9: Instructions

Follow these instructions to ensure your request is properly submitted and received by Mutual of Omaha. Be sure to include the Group ID Number on any payment, and mail the request form and the payment to Mutual of Omaha as soon as possible after your coverage ends under the group plan.

Remember, to be considered for coverage under the Term Life Portability Plan, your request must be received within 31 days of the date coverage under the group plan ended.

*The ages referenced in Sections 2 and 3 represent Attained Age, which is the age of any individual as of the policy anniversary date of October 1 of a given year. For example, lets say you are 69 years old on October 1, 2015. Your Attained Age for the policy year (October 1, 2015 – September 30, 2016) is 69, even if your 70th birthday is in November. In this example, you are eligible for coverage under this plan until September 30, 2016.

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

**Group Portability**
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (877) 466-8367

# Term Life Portability Request Form

Please refer to "A Guide for Successfully Completing the Term Life Portability Request Form" when completing this form. Please consult the employer/benefits administrator if you need assistance with information for the form.

**Section 1: Group Information and Date of Hire/Association** (Please print clearly. Required fields are marked with an asterisk (*).)

Group/Employer Name*: Roman Catholic Diocese of Owensboro

Group ID Number*: G000 ___ ___ ___ ___

Date of Hire/Association (MM/DD/YYYY)*:

**Section 2: Applicant Information** (Please print clearly. Required fields are marked with an asterisk (*).)

Last Name* | First Name* | MI

Street Address* | Email Address

City* | State* | ZIP Code* | Telephone*

Birth Date (MM/DD/YYYY)*† | Social Security Number* | Gender*

*†The applicant must be the Attained Age of 70 or less to be eligible for insurance.*

❑ Female ❑ Male

Consent to Email Correspondence
❑ Check this box if you consent to receiving future correspondence regarding this request via email.

Applicant Type*
❑ Employee/Member
❑ Spouse

Individuals for Whom Ported Insurance is Being Requested* (†Applies to employee/member applicants)
❑ Myself ❑ Myself & Spouse† ❑ Myself, Spouse & Child(ren)† ❑ Myself & Child(ren)

Reason for Request*
If you are an employee/member applicant, indicate why you are requesting insurance, and provide the date (MM/DD/YYYY) as requested:
❑ Status Change/Reduction in Hours Date of Change: _____
❑ Employment/Association Terminated Date of Termination: _____
❑ Plan Terminated by Group/Employer Date of Termination: _____
❑ Employee/Member Retirement Date of Retirement: _____

If you are a spouse applicant, please indicate why you are requesting insurance, and provide the date (MM/DD/YYYY) as requested:
❑ Divorce Date of Divorce: _____
❑ Death of Employee/Member Date of Death: _____
❑ Ineligible Due to Employee/Member Age Date of Ineligibility: _____
❑ Ineligible Due to Employee/Member Active Military Status; Date of Ineligibility: _____

**Section 3: Dependent Information** (Please print clearly. All fields are required for any dependents requesting insurance.)

| Dependent Type | Last Name | First Name | MI | Date of Birth† (MM/DD/YYYY) | Gender |
|---|---|---|---|---|---|
| ❑ Spouse ❑ Child | | | | | ❑ Female ❑ Male |
| Child | | | | | ❑ Female ❑ Male |
| Child | | | | | ❑ Female ❑ Male |
| Child | | | | | ❑ Female ❑ Male |
| Child | | | | | ❑ Female ❑ Male |
| Child | | | | | ❑ Female ❑ Male |

*†A spouse must be the Attained Age of 70 or less and children must be the Attained Age of 26 or less to be eligible for insurance.*

**Section 4: Current Term Life Insurance Amount(s) Eligible for Portability** (Please print clearly.)

| | Applicant* | Spouse (If applicable) | Child(ren) (If applicable) |
|---|---|---|---|
| Eligible Insurance Amount | $ | $ | $ |

**Section 5: Monthly Rates Per $1,000 of Insurance**

| | Employee/Member and Spouse Rates | | | | | | | | | | Child Rate |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Age | 0 - 24 | 25 - 29 | 30 - 34 | 35 - 39 | 40 - 44 | 45 - 49 | 50 - 54 | 55 - 59 | 60 - 64 | 65 - 69 | All Ages |
| Life Rate | $0.173 | $0.173 | $0.194 | $0.248 | $0.395 | $0.642 | $1.009 | $1.660 | $2.533 | $4.083 | $0.120 |
| AD&D Rate | $0.060 (applies to Employee/Member, Spouse and Child for all ages) | | | | | | | | | | |

*†The ages referenced in Sections 2 and 3 represent Attained Age, which is the age of any individual as of the policy anniversary date of October 1 of a given year. For example, lets say you are 69 years old on October 1, 2016. Your Attained Age for the policy year (October 1, 2015 - September 30, 2016) is 69, even if your 70th birthday is in November. In this example, you are eligible for insurance under this plan until September 30, 2016.*

## Section 6: Portability Insurance Election & Initial Premium Payment Calculation

Type of Insurance Requested

❑ Life Insurance Only ❑ Life and AD&D Insurance *(This option can only be selected if an AD&D rider was available under the group plan)*

Initial Premium Payment Calculation

| | (1) First Name | (2) Insurance Amount | (3) Coverage Factor (2) / 1,000 | (4) Monthly Rate Life + AD&D if applicable | (5) Monthly Premium (3) X (4) | (6) Total Monthly Premium Sum of column (5) amounts | (7) Billing Frequency | (8) Initial Premium Payment (6) X (7) |
|---|---|---|---|---|---|---|---|---|
| Applicant | | | | | | | | |
| Spouse | | | | | | | | |
| Child | | | | | | | | |
| Child | | | | | | $ _____ | _____ | $ _____ |
| Child | | | | | | | | |
| Child | | | | | | | | |
| Child | | | | | | | | |

## Section 7: Beneficiary For Death Benefits

**Important Note:** AZ, CA, ID, LA, NV, NM, TX, WA and WI are community property states. If you live in a community property state and you designate someone other than your spouse as a beneficiary, state law requires that your spouse consent to such designation. If you do not obtain your spouse's consent to the foregoing designation(s), then such designation(s) may not be effective.

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Unless otherwise expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designated beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s).

Primary Beneficiary Designation

| Last Name | First Name | Relationship to Applicant | Date of Birth (MM/DD/YYYY) | Address of Beneficiary (Address, City, State, ZIP) | Benefit Percentage (%) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | Percentage Total: | 100% |

Secondary Beneficiary Designation

| Last Name | First Name | Relationship to Applicant | Date of Birth (MM/DD/YYYY) | Address of Beneficiary (Address, City, State, ZIP) | Benefit Percentage (%) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | Percentage Total: | 100% |

## Section 8: Eligibility Conditions

To be eligible for Life continuation insurance, you satisfy the following conditions:

- You have not received a living benefit payment.

## Section 9: Acknowledgement and Signature

I understand that I may request insurance under the portability plan subject to the following:

- I understand that this insurance is subject to the rules of the policy governing the portability plan.
- I understand that the individuals covered under this plan must satisfy the plan's requirements to be eligible for benefits and that payment of premium does not ensure eligibility for insurance. In the event that any premium is collected after eligibility for portability insurance ceases, I understand that the unearned premium will be refunded in accordance with the terms of the policy governing the portability plan.
- This request for insurance must be received by Mutual of Omaha within 31 days of the date that insurance ceased under the group plan.
- My request is subject to review and acceptance by Mutual of Omaha.
- Premium amounts may increase if any of the individuals insured under the plan enter a higher premium age category, or if portability plan experience requires a change for all individuals insured under the plan.

By signing below, I acknowledge that I understand and agree to the above statements.

SIGNATURE OF APPLICANT _____ DATE _____/_____/_____

## Section 10: Instructions

1) Mail this completed and signed form with the Initial Premium Payment to Mutual of Omaha as soon as possible after insurance has ceased under the group plan. The form and payment must be received by Mutual of Omaha within 31 days of the date insurance under the group plan ended.
2) Make the check or money order for the Initial Premium Payment payable to United of Omaha Life Insurance Company. Be sure to include the Group ID Number (from Section 1) on the payment.
3) Submit this form and payment to:
   Mutual of Omaha
   Policyowner Services
   P.O. Box 2147
   Omaha, NE 68103-2147

If you have any questions regarding this form, please contact the employer/benefits administrator, or contact Mutual of Omaha toll-free at (877) 466-8367.

# Fraud Warnings

**Required Fraud Warnings (State specific warnings apply to the resident of such state)**

**Fraud Warning:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**Arkansas/Kentucky/Louisiana/Maine/New Mexico/ Ohio/Tennessee:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**California:** For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Kansas:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as determined by a court of law.

**Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Oregon:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

**Puerto Rico:** Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the fixed penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Vermont:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

**Virgin Islands:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal penalties.

**Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (800) 826-8054

# Life Conversion Coverage

## Life Goes on with Group Conversion

Your group life insurance has been valuable protection for you and your family. Now that it will be terminated, you may wish to convert this important coverage to an individual policy. This information has been prepared to help you take advantage of your right to continue your protection.

## About Life Conversion Coverage

Life Conversion Coverage is individual permanent life insurance issued without evidence of insurability.

Life Conversion Coverage can be obtained when your life insurance under the group policy ends. Your group certificate will describe when conversion coverage is available to you, and will show the amount of coverage you can convert.

Conversion coverage will be issued without evidence of good health, provided:

(a) you complete the attached application,
(b) you enclose a check or money order for the first premium payment and
(c) these items are forwarded to us within 31 days after your group insurance ends.

Your conversion policy will be effective on the 31st day after your group insurance ends. During this 31-day period, you remain covered under the continued coverage provision of your group certificate.

You may apply for an amount that is not more than the amount of your current group insurance coverage (this is your maximum). You may elect coverage in $1,000 increments up to your maximum.

The individual policy is Permanent Life Insurance, which provides a level benefit throughout your lifetime. Premiums for this coverage are payable while living until the policy anniversary following age 100.

Premium rates are shown in the table that follows. If premium payments are discontinued after your coverage has been issued, you may:

(a) receive any existing cash value or
(b) use the cash value to purchase extended term insurance or a reduced amount of paid-up life insurance.

For additional information or premium rates on conversion coverage, please write or call us at:

Attn: Group Policy Services, Group Conversion
United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Phone: 1-800-826-8054

## To Apply for Life Conversion Coverage

In order to apply for life conversion coverage, you must do the following:

1) Complete the Life Conversion Application that follows. Use black or blue ink. Write clearly and do not erase – any corrections should be crossed out and initialed by you. Answer each question fully – do not use dashes or ditto marks.

2) Make sure the section entitled "Information to be Completed by the Personnel Office" is completed by the employer or administrator of the group policy.

3) Attach your check or money order payable to United of Omaha Life Insurance Company for the first annual, semiannual or quarterly premium payment.

4) Send your premium payment and completed application to the above address and must be received within 31 days after your group insurance ends.

**Privacy Notice:** When United of Omaha Life Insurance Company evaluates an application for life conversion coverage, only the information on the application is reviewed. This information, and other information we may later collect to administer coverage, may sometimes be disclosed without your express authorization. We have a procedure which allows you to review and amend any information we collect about you – other than information relating to a claim, lawsuit or criminal proceeding. If you would like to know more about our information practices, please write us at the address shown above.

## Calculating the Premium

The premium amounts in the table below are per $1,000 of coverage. Calculate your annual, semiannual or quarterly premium in the calculation worksheet, following the steps and example below.

### To Calculate Annual, Semiannual and Quarterly Premium:

1) Divide your desired death benefit amount by 1,000.
2) Locate your age group and gender on the table below to identify the premium rate per thousand.
3) Multiply #1 by #2 above.
4) Add $36 for the annual policy fee to obtain the **annual premium** for the coverage.
5) Multiply the annual premium by .52 to obtain the **semiannual premium** for the coverage.
6) Multiply the annual premium by .275 to obtain the **quarterly premium**.

| Rate/$1,000 | | |
|---|---|---|
| Issue Age | Female | Male |
| 0-4 | 4.33 | 4.33 |
| 5-9 | 5.32 | 5.32 |
| 10-14 | 6.18 | 6.18 |
| 15-17 | 8.10 | 8.10 |
| 18-19 | 9.00 | 10.00 |
| 20-24 | 10.50 | 11.60 |
| 25-29 | 12.50 | 13.80 |
| 30-34 | 14.50 | 16.50 |
| 35-39 | 17.00 | 20.00 |
| 40-44 | 19.50 | 24.99 |
| 45 | 21.80 | 24.99 |
| 46 | 22.27 | 25.81 |
| 47 | 22.86 | 26.76 |
| 48 | 23.57 | 27.82 |
| 49 | 23.91 | 28.45 |
| 50 | 24.12 | 29.16 |
| 51 | 25.00 | 30.45 |

| Rate/$1,000 | | |
|---|---|---|
| Issue Age | Female | Male |
| 52 | 25.48 | 31.37 |
| 53 | 26.31 | 32.58 |
| 54 | 27.26 | 34.16 |
| 55 | 28.31 | 35.83 |
| 56 | 29.29 | 37.36 |
| 57 | 30.17 | 38.99 |
| 58 | 31.04 | 40.52 |
| 59 | 32.02 | 42.26 |
| 60 | 33.33 | 44.44 |
| 61 | 35.18 | 47.39 |
| 62 | 36.92 | 50.22 |
| 63 | 38.78 | 53.16 |
| 64 | 40.63 | 56.11 |
| 65 | 42.48 | 59.05 |
| 66 | 45.21 | 63.08 |
| 67 | 47.93 | 67.11 |
| 68 | 50.66 | 71.15 |

| Rate/$1,000 | | |
|---|---|---|
| Issue Age | Female | Male |
| 69 | 53.49 | 75.18 |
| 70 | 56.22 | 79.21 |
| 71 | 60.03 | 84.44 |
| 72 | 63.95 | 89.57 |
| 73 | 68.23 | 95.29 |
| 74 | 72.56 | 101.07 |
| 75 | 77.76 | 108.23 |
| 76 | 84.32 | 116.48 |
| 77 | 90.23 | 124.09 |
| 78 | 95.77 | 131.07 |
| 79 | 101.36 | 138.23 |
| 80 | 107.00 | 145.45 |
| 81 | 115.74 | 157.07 |
| 82 | 124.44 | 168.92 |
| 83 | 132.70 | 180.01 |
| 84 | 140.84 | 191.10 |
| 85 | 149.10 | 202.19 |

## **Example** (Assumes a 50-year-old male with current group life coverage of $20,000.)

20 (Desired coverage amount/$1,000) x $29.16 (Premium rate per thousand) = $583.20 (Premium for coverage) + $36 (Annual policy fee) = $619.20 (**Total annual premium**)

$619.20 (Total annual premium) x .52 = $321.98 (**Total semiannual premium**)

## Calculation Worksheet

_____ (Desired coverage amount/$1,000) x _____ (Premium rate per thousand) = _____ (Premium for coverage) + $36 (Annual policy fee) = $_____ (**Total annual premium**)

_____ (Total annual premium) x .52 = _____ (**Total semiannual premium**)

# Conversion Application

This completed application with premium payment must be received within 31 days after your group insurance ends. Mail the conversion to: **Attn: Group Policy Services**, Group Conversion, United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175.

## Life Insurance Section

1) Applicant's Name (First, Middle, Last)

_____

2) Social Security Number

_____

3) ❑ Male ❑ Female

4) Age _____ 5) Date of Birth _____ _____ _____
Month Day Year

6) Residence (Number, Street, City, State ZIP)

_____

_____

7) Home Phone Number ( _____ ) _____

8a) Amount of Insurance $ _____
(Show amount in thousands, not greater than the amount you are entitled to convert.)

8b) Has a living benefit been paid? ❑ Yes ❑ No

9) Mode of Premium Payments
❑ Annually ❑ Semiannually ❑ Quarterly

10) Amount Paid with Application

$ _____
Important: If a living benefit has been paid, the full amount of coverage must be continued.

11) Beneficiary Information

*Primary Beneficiary*

Full Name _____

Relationship to Applicant _____

*Secondary Beneficiary*

Full Name _____

Relationship to Applicant _____

Payment will be shared equally by all primary beneficiaries who survive you; if none, it will be shared equally by all contingent beneficiaries who survive you. Unless otherwise stated, you have the right to change the beneficiary.

## Group Insurance Section

1) Group Policyholder _____

Group Policy No. _____

2) I have been insured under the above Group Policy as:
❑ An employee or member ❑ A dependent

3) I became insured under the Group Policy:

_____ Month _____ Day _____ Year

4) My group insurance terminated:

_____ Month _____ Day _____ Year

5) Was termination due to disability? ❑ Yes ❑ No
(If "Yes," give date and cause of disability.)

_____

## Life Agreements Section

I am applying to United of Omaha for the life conversion coverage shown above. I agree United will not be under any obligation or liability under this application unless:

1) I have the right to convert the insurance shown above.

2) The application is fully completed, premium payment enclosed and received within 31 days after my group insurance ends.

Date _____ , _____

State signed in _____

Applicant's
Signature _____

Whole Life Policy Form ICC17L161P, or state equivalent. In CT, D662LCT17P. In FL, D654LFL17P. In ND, D658LND17P. In SD, D656LSD17P.

## Information to be Completed by the Personnel Office

Group Policyholder _____

Policy No. _____ Phone ( _____ ) _____

Address (Number, Street, City, State ZIP) _____

Applicant's Name _____

Certificate No. _____

1) The Applicant was insured under the above Group Policy as: ❑ An employee or member ❑ A dependent

2) For what amount of coverage was the Applicant insured? $ _____

3) What is the Applicant's date of birth? _____ Month _____ Day _____ Year

4) When did the Applicant become insured under the Group Policy? _____ Month _____ Day _____ Year

5) The Applicant's coverage was: ❑ terminated on _____ Month _____ Day _____ Year

❑ reduced by $ _____on _____ Month _____ Day _____ Year

6) On what date was the Applicant notified of their right to continue this life insurance coverage? _____

Because of _____

_____

Completed by _____ Signature (Employer or Administrator)

Title _____ Date_____ , _____

# Fraud Warnings

**Required Fraud Warnings (State specific warnings apply to the resident of such state)**

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**Puerto Rico:** Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the fixed penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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**Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Diocese of OWENSBORO

***Confidential***

# Employee Exit Interview Form

Date: _____

Name: _____

Location/Department: _____ Supervisor: _____

Hire Date: _____Termination Date: _____

Starting Position: _____Ending Position: _____

Starting Salary: _____Ending Salary: _____

## Part 1: Reason for Leaving

(More than one reason may be given if appropriate; if so, circle the primary reason.)

### Reason for Resignation:

___Took another positon

___Pregnancy/home/family needs

___Poor health/physical disability

___Relocation to another city

___Travel difficulties

___To attend school

___ Other: _____

### Dissatisfaction with:

___ Salary

___ Type of work

___ Supervisor

___ Co-workers

___ Working conditions

___Benefits

___ Other: _____

### Laid off due to:

___ Lack of work

___ Abolition of position

___ Lack of funds

___ Other: _____

### Type of Retirement:

___ Voluntary retirement

___ Disability retirement

___ Regular retirement

### Plans after leaving:

_____

_____

_____

## Part II: Comments/Suggestions for Improvement

We are interested in what our employees have to say about their work experience with the Diocese of Owensboro. Please complete this form.

1. What did you like most about your job?

_____

_____

2. What did you like least about your job?

_____

_____

3. How did you feel about the pay and benefits?

| | Excellent | Good | Fair | Poor |
|---|---|---|---|---|
| Rate of pay for your job | ☐ | ☐ | ☐ | ☐ |
| Paid holidays | ☐ | ☐ | ☐ | ☐ |
| Paid vacations | ☐ | ☐ | ☐ | ☐ |
| Retirement plan | ☐ | ☐ | ☐ | ☐ |
| Medical coverage for self | ☐ | ☐ | ☐ | ☐ |
| Medical coverage for dependents | ☐ | ☐ | ☐ | ☐ |
| Life Insurance | ☐ | ☐ | ☐ | ☐ |
| Sick leave | ☐ | ☐ | ☐ | ☐ |

4. How did you feel about the following:

| | Very Satisfied | Slightly Satisfied | Neutral | Slightly Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|---|
| Opportunity to use your abilities | ☐ | ☐ | ☐ | ☐ | ☐ |
| Recognition for the work you did | ☐ | ☐ | ☐ | ☐ | ☐ |
| Training you received | ☐ | ☐ | ☐ | ☐ | ☐ |
| Your supervisor's management methods | ☐ | ☐ | ☐ | ☐ | ☐ |
| The opportunity to talk with your supervisor | ☐ | ☐ | ☐ | ☐ | ☐ |
| The information you received on policies, programs, projects, and problems. | ☐ | ☐ | ☐ | ☐ | ☐ |
| Promotion Policies and practices | ☐ | ☐ | ☐ | ☐ | ☐ |
| Discipline policies and practices | ☐ | ☐ | ☐ | ☐ | ☐ |
| Overtime policies and practices | ☐ | ☐ | ☐ | ☐ | ☐ |
| Performance review | ☐ | ☐ | ☐ | ☐ | ☐ |
| Physical working condition | ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments:**

_____

_____

_____

_____

5. If you are taking a new job…
    a. What kind of work will you be doing?

_____

_____

b. What has your new place of employment offered you that is more attractive than your present job?

_____

_____

6. Could your employer have made any improvements that might have influenced you to stay on the job?

_____

_____

Other remarks (optional):

_____

_____

_____ _____

Employees Signature Date

**DO NOT WRITE BELOW THIS LINE. OFFICE USE ONLY. PLEASE RETURN TO YOUR EMPLOYER.**

---

( ) *Discussed with employee*

☐ *Benefits*

☐ *Payment of unused time and last paycheck*

_____

_____ _____

Interviewer's Signature Date