

Social Security No.	Legal Name (Last)	(First)	(Middle)
Home Address (Street)		(City)	(State) (Zip + four)
Home # ( )	Birthdate (Month, Date, Year)	Marital Status	Sex (M/F)
Cell # ( )	Name and Address of Parish/School/Office Where Employed		
Employment Start Date:		Position/Job Title:	
Full Time/Part Time _____		# of hours per week _____	
List All Dependents			
Full Name	Birthdate (Month, Date, Year)	Social Security Number	
Spouse			
( ) Son			
( ) Daughter			
( ) Son			
( ) Daughter			
( ) Son			
( ) Daughter			
( ) Son			
( ) Daughter			
Please complete No. 1, 2, and 3			
<b>Number 1</b> ( ) Hispanic or Latino ( ) White (not Hispanic or Latino) ( ) Asian (not Hispanic or Latino) ( ) Black or African American (not Hispanic or Latino) ( ) American Indian or Native Alaskan (not Hispanic or Latino) ( ) Other _____			
<b>Number 2</b> Military Veteran ( ) Yes ( ) No Military Reserve ( ) Yes ( ) No Branch of Service _____ If yes, ( ) Active ( ) Inactive			
<b>Number 3 Circle the highest year of education</b> Less than 12th grade High School Graduate Some college/business school Vocational/Technical School Two-year College Graduate Bachelor's Degree Master's Degree Doctorate Degree Other _____			

### Health Insurance

If eligible for Diocesan Health Insurance, check for Medical and/or Dental Coverage

**Medical: PPO**

Employee only ( )      Parent/Child ( )      Parent/Children ( )      Employee/Spouse ( )      Family ( )

**Dental:**

Non-Teachers eligible for Dental after completing one year of full time employment.

Teachers are eligible for single dental coverage when originally eligible for health insurance.

Dependents of Teachers are eligible after completing one year waiting period.

Employee only ( )      Family ( )

**Other Insurance:**

Does your Spouse have other Insurance ( ) Yes      ( ) No      If yes, please complete the following:

Carrier Name: \_\_\_\_\_

Group #: \_\_\_\_\_

Circle all that apply:              Medical                      Dental

Does your Spouse's insurance cover your dependents: ( ) Yes      ( ) No

### Emergency Contact

Name	Relationship	Home Telephone
Name of work location		Work Telephone

### DIOCESAN EMPLOYMENT HISTORY

IF YOU HAD PRIOR DIOCESAN WORK EXPERIENCE PLEASE COMPLETE INFORMATION BELOW:

1) Place of employment: \_\_\_\_\_

Address: \_\_\_\_\_

Employed from \_\_\_\_\_ to \_\_\_\_\_      Number of hours per week \_\_\_\_\_

2) Place of employment: \_\_\_\_\_

Address: \_\_\_\_\_

Employed from \_\_\_\_\_ to \_\_\_\_\_      Number of hours per week \_\_\_\_\_

3) Place of employment: \_\_\_\_\_

Address: \_\_\_\_\_

Employed from \_\_\_\_\_ to \_\_\_\_\_      Number of hours per week \_\_\_\_\_

PLEASE SEND COPY TO THE HUMAN RESOURCES OFFICE    FAX 610-439-7693