



# DONNELLY COLLEGE

## EMPLOYEE BENEFIT CHANGE FORM

Employee Name: \_\_\_\_\_

\_\_\_\_\_ Department

Benefit Change Date: \_\_\_\_\_

	Change Amount	Add/Term
Benefits: Health	_____	_____
Dental	_____	_____
Vision	_____	_____
Flexible Spending Account	_____	_____
Life/Disability	_____	_____
403 B Retirement	_____	_____

\_\_\_\_\_  
Becky Dowell

\_\_\_\_\_  
Lorrie Townsend