Employee Benefits Termination of Form

Health Benefits Administration | Seventh-day Adventist Church in Canada
1148 King Street East, Oshawa, ON L1H 1H8 | 1-800-263-7868

Send to HBA by Termination of Employment Date

Employer: _____

EMPLOYEE INFORMATION

Last Name: _____

First Name: _____

Date of Birth: _____
dd-mmm-yyyy

Last Day of Active Employment: _____
dd-mmm-yyyy

Date to Terminate Benefits: _____
dd-mmm-yyyy

Are benefits being offered as a part of a termination settlement?

☐ Yes **If YES, (LTD) Indicate how many weeks of minimum statutory notice:** _____

☐ No

Option to convert Life Insurance and Personal Accident Protection Plan was explained to employee?

☐ Yes

☐ N/A (65 yrs+ for Life Insurance / 70 yrs+ for Accident Protection)

To your knowledge, is the employee transferring to another denominational employer in Canada?

☐ Yes **If YES, list new employer:** _____

☐ No

Reason for termination:

_____

_____

Completed By: _____ Date: _____
Name dd-mmm-yyyy