COVENANT BENEFITS

Post Office Box 316560, Chicago, Illinois 60631 | FAX: (773) 784-2249 | EMAIL: benefits@covchurch.org

Termination of Benefits or Employment

Instructions: Fill out and return this form to Bethany Benefit Service. If the policyholder is opting out of health insurance and wishes to continue life and long-term disability benefits, please complete the Waiver of Health Insurance Form. *Please print legibily.*

1. YOUR INFORMATION

Name: _____ SSN: _____

Effective Date of Change: _____ / _____ / _____ *(Coverage will continue until the end of the given month.)*

2. REASON FOR TERMINATION

Select one.

☐ **Policyholder and/or employer elected alternate insurance coverage.** Please note that following termination of insurance benefits, re-enrollment will only be available during Open Enrollment Period.

☐ **Hours worked per week reduced** below minimum required limits.

☐ **Retirement.** Policyholder will be notified if eligible to continue receiving benefits at his/her own expense into retirement.

☐ **Termination of employment.** Please answer the following questions:

a. Is extended health insurance included as part of a severance package?

☐ No ☐ Yes, until _____ / _____ / _____

(Note: When offering extended benefits in a severance epackage, life and long-term disability are not included.)

b. As far as you are aware, has the policyholder accepted another position within the Evangelical Covenant Church?

☐ No ☐ Yes. Location: _____

3. POLICYHOLDER CONTACT INFORMATION (FOR COBRA PURPOSES)

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____ Phone #: _____

4. AUTHORIZED SIGNATURE

This form, signed by the policyholder or an authorized representative of the employer (treasurer, business manger, etc.), is to request the termination of benefits or employment for the indicated policyholder as stated above.

Signature: _____ Date: _____ / _____ / _____

Employer Name: _____