Chambers of Commerce Group Insurance Plan®

JG11-CH

EMPLOYEE TERMINATION / REINSTATEMENT REQUEST

TO BE COMPLETED BY THE EMPLOYER (IN INK)

Company Name _____ Firm # _____

Employee Name _____ Certificate # _____

Plan Administrator's Name _____

Plan Administrator's Signature _____ Date _____

TERMINATE EMPLOYEE'S COVERAGE

Employee Left Employment

All benefits except disability stop at the end of the month in which the employee left employment. Disability benefits stop the day the employee stops working.

❑ Terminate ALL Coverage Last Day of Work (YYYY/MM/DD) _____

Leave of Absence / Temporary Lay Off

During a leave or lay off, an employer can continue to offer the coverage held by the individual on a premium-paying basis with the exception of Long Term Disability, Weekly Indemnity and Critical Illness* coverage. In order for insurance to continue, we must be notified before the leave starts and provided with a scheduled return to work date. The continuation cannot exceed six months.

**If the leave or layoff is 4 months or less, Critical Illness coverage can be continued on a premium-paying basis.*

❑ Terminate ALL Coverage Last Day of Work (YYYY/MM/DD) _____

OR

❑ Continue Employee's Coverage Last Day of Work (YYYY/MM/DD) _____

Scheduled Return to Work _____

Maternity Leave

During a maternity leave individuals may either:

- terminate coverage** and have it reinstated provided they return within twelve (12) months and we are notified within thirty-one (31) days of their return, or
- continue to pay the premium and be covered for all benefits. Disability benefits would not be paid while on maternity leave but would be paid if they became disabled while on leave which resulted in them not being able to return to work when expected.

❑ Terminate ALL Coverage Last Day of Work (YYYY/MM/DD) _____

OR

❑ Continue ALL Coverage Last Day of Work (YYYY/MM/DD) _____

Scheduled Return to Work _____

***Insureds in Quebec can only terminate coverage if they are covered under their spouse's group insurance plan.*

Name of Insurer _____

Other

❑ Terminate ALL Coverage Last Day of Work (YYYY/MM/DD) _____

Provide reason _____

REINSTATE EMPLOYEE'S COVERAGE

Coverage may be reinstated provided the individual returns within six (6) months of the termination date and we are notified in writing within thirty-one (31) days of their return date. Coverage is effective on the first day of the month following the date of return, not the date of notification.

❑ Reinstate ALL Coverage Date of Return (YYYY/MM/DD) _____