



COMPLETE THIS FORM IF AN EMPLOYEE IS ENDING ACTIVE COVERAGE

Active coverage ends effective the 1st day of the month following the last day of active employment coverage.

ENDING ACTIVE COVERAGE INFORMATION

- Once an employee has ended active employment, the Alliance Benefits Office must be notified via this form within 30 days.
- The first of the month after active employment ends, the employee may be eligible for coverage extension (because we are a church group plan, we are unable to offer COBRA but offer something similar called Coverage Extension).
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- Coverage Extension is the same coverage the employee had for active coverage, minus the Life Insurance and Long Term Disability (if applicable). Alliance Benefits will offer the number of months that they were on active coverage up to 12 months maximum or until they become eligible for other coverage, whichever comes first.
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- The former employer may choose to cover up to 3 months of coverage extension (if at least 3 months are available) as part of a severance package if they wish but that will be deducted from the total number of coverage extension months available.
- Life Insurance coverage and Long Term Disability coverage will end on the last day of the month in which employment ends and may NOT be extended during a severance period. We may be able to offer conversion if we are promptly informed. Please contact the Alliance Benefits Office for details.

EMPLOYEE INFORMATION (to be completed by authorized person from the Church/District)

Employee Name: _____ **Employee Email:** _____

Employee Contact Information (to send Coverage Extension information):

ADDRESS	CITY	ST	ZIP
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Employer (Church/District) Name: _____ **Church Code:** _____

Last Day of Active Employment: ____/____/____ k . O h

Do you the employer wish to pay for any coverage extension? YES NO If yes, how many months? 1 2 3

PLEASE NOTE: The employee is covered for the remainder of the month under regular coverage (which includes the Life Insurance coverage as well as the Long Term Disability coverage) after their last day actively employed. The option for coverage extension begins the first of the month following the last day of active employment.

AUTHORIZING SIGNATURE (to be completed by authorized person from the Church/District)

- I understand that the employee is covered for the remainder of the last active month of employment under regular coverage.
- I understand that if I indicated that we the employer would pay for any coverage extension, that we will be charged monthly for the number of months indicated and this withdrawal will come from the church account that the Alliance Benefits has on file.
- I agree to pass along a copy of this document to the concluding employee so they are aware of the coverage termination information.

Signature

Date

FOR ALLIANCE BENEFITS OFFICE USE ONLY

Employee on plan for at least 12 months? YES NO If no, how many months? _____

Dates Employer Covering ____/____/____ - ____/____/____ Dates Available to Employee ____/____/____ - ____/____/____