

Health Benefits Trust Fund

Termination of Coverage

- Please print clearly.
- Please retain a photocopy for your files.
- Please sign and date this form and immediately return to Doctors of BC by FAX: 604 638 2909 or EMAIL: insurance@doctorsofbc.ca

1a) Termination of Employee's Coverage (except Parental Leave)

Benefits cease upon termination of employment. Any extension of coverage due to severance arrangements beyond the statutory limit is subject to approval by the Insurer. Please contact the Plan Administrator (Doctors of BC) in this event.

For termination of coverage due to Parental Leave, complete 1b) below.

ALL terminations will take place as of the first of the month following receipt of this form

Coverage is no longer required for the following employee(s):

		Last Day Worked
Last Name	First Name	mm dd yyyy
Reason for Termination (e.g. termination of employment, retired, quit, working less than 20 hours/week)		

		Last Day Worked
Last Name	First Name	mm dd yyyy
Reason for Termination (e.g. termination of employment, retired, quit, working less than 20 hours/week)		

		Last Day Worked
Last Name	First Name	mm dd yyyy
Reason for Termination (e.g. termination of employment, retired, quit, working less than 20 hours/week)		

1b) Termination of Employee's coverage (Parental Leave)

NOTE: If the employer is paying 100% of the cost of benefits, all benefits must be continued for the duration of the Parental Leave.

		Last Day Worked
Last Name	First Name	mm dd yyyy

I am paying a portion of the cost of benefits and elect to terminate coverage.

Employee Signature	Date

2. Withdrawal from Program (Physician or entire office)

NOTE: Premium must be paid up to effective date of withdrawal.

ALL terminations will take place as of the first of the month following receipt of this form.

We no longer wish to participate in the Health Benefits Trust Benefits Plan for the following reason(s):

(Please check all that apply)

<input type="checkbox"/> retirement	<input type="checkbox"/> office closing/moving	<input type="checkbox"/> working less than 20 hrs/week
<input type="checkbox"/> coverage inadequate	<input type="checkbox"/> price too high	
<input type="checkbox"/> alternate coverage:	Name of your new insurance company	
<input type="checkbox"/> other reason:	Please explain	

3. Employer/Physician Information

This section **MUST** be completed.

Name of Physician or Employer	Business ID
Employer/Physician's Signature	Date