03/21

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.

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 Name | First Name | Last Day Worked (mm dd yyyy)

Reason for Termination (e.g. termination of employment, retired, quit, working less than 20 hours/week)

Last Name | First Name | Last Day Worked (mm dd yyyy)

Reason for Termination (e.g. termination of employment, retired, quit, working less than 20 hours/week)

Last Name | First Name | Last Day Worked (mm dd yyyy)

Reason for Termination (e.g. termination of employment, retired, quit, working less than 20 hours/week)

1b) Parental Leave Coverage Termination

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 Name | First Name | Last Day Worked (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)

- ☐ retirement
- ☐ office closing/moving
- ☐ working less than 20 hrs./week
- ☐ coverage inadequate
- ☐ price too high
- ☐ alternate coverage: Name of your new insurance company
- ☐ 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

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