CHRISTIAN BROTHERS SERVICES

Employee Benefit Trust
1205 Windham Parkway
Romeoville, IL 60446
800.807.9460 / 630.378.3005 fax

STATEMENT OF CHANGE OF ACTIVE EMPLOYMENT

APPLIES TO ANY MEDICAL/DENTAL AND/OR VISION COVERAGES

PART 1. TO BE COMPLETED BY EMPLOYER | *****CHECK ALL BOXES THAT APPLY*****

Employer Name:		Location #:	
Employee Name:		Social Security #:	
Date of Birth:		Actual Last Day Worked:	

☐ Disability
☐ Death: Date_____
☐ Retirement (Please complete questionnaire below)
☐ Termination/Resignation
☐ Other (attach explanation to this form)
☐ Cancel Retiree Continuation; Date_____
☐ Cancel Medical Extension; Date_____
☐ Teacher/Contract Ends: Date_____
☐ Leave of Absence-Medical
☐ Leave of Absence-FMLA
☐ Leave of Absence-Personal
☐ Reduction of Work Hours # of Hours_____Date_____

Dependents: (Information needed to meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Dependent Name:		Social Security #:	
Dependent Name:		Social Security #:	
Dependent Name:		Social Security #:	
Signature of Employee:		Date:	

PART II. PLEASE READ CAREFULLY AND COMPLETE SECTION BELOW IF CONTINUING COVERAGE.

An employee whose group coverage terminates due to a reduction of work hours or termination of employment (other than for gross misconduct) can continue benefits for himself or herself and his/her covered dependents for up to 18 months. Coverage cannot be continued if the person is covered under another group plan, or if the person is eligible for Medicare.

- A disabled person who receives a social security award could extend group benefits an additional 11 months or until Medicare becomes effective, or other coverage is in effect, whichever is earlier.
- Coverage cannot be continued if the proper contributions are not made or if the group plan terminates.
- An individual/dependent must have been enrolled for group coverage for at least three months to be eligible to extend coverage(except approved Leave of Absences).
- Please refer to Your Employee Benefits Booklet for eligible retiree requirements.

Please check one:

☐ I do not elect to continue benefits under the group plan.
☐ I elect to continue my benefits under the group plan. Please continue coverage for:
☐ Employee ☐ Employee and Eligible Dependents

NOTE: If you are moving, please fill out the Change of Address form and send it in with this form. Otherwise, any certificates or EOB's will be delayed. You must also advise the employer, *in writing,* in the event you are no longer eligible for continuation or you no longer wish to continue your optional benefits.
I certify that I am not covered under any other group insurance plan at this time, nor eligible for Medicare.
(please disregard if continuing as an eligible retiree or on an approved Leave of Absence).

Name of Person Making Election:		Date:	
Signature of Person Making the Election:			

QUESTIONNAIRE TO BE COMPLETED BY THE EMPLOYER IF RETIREMENT IS MARKED ABOVE.

The following questions will assist in our determination of who will be the primary payor on the retiree; CBEBT or Medicare.

1. Will the retiree be paid for any accrued sick time? ☐ Yes ☐ No
If yes, thru what date will the retiree be paid? _____
2. Will the retiree be paid for any accrued vacation time? ☐ Yes ☐ No
If yes, thru what date will the retiree be paid?_____
3. What is the date of retirement which you are reporting to Medicare?
4. If employee is under 62, are they collecting from a ☐ pension or ☐ retirement plan?

Signature of Benefits Administrator:	