



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

Statement of Change of Active Employment

Part 1 - To Be Completed By Employer

Employer Name <input type="text"/>		Employee Name <input type="text"/>	
Social Security Number <input type="text"/>	Location Number <input type="text"/>	Date of Birth <input type="text"/>	Actual Last Day Worked <input type="text"/>

(Check all boxes that apply)

- | | |
|---|---|
| <input type="checkbox"/> Disability | <input type="checkbox"/> Cancel Medical Extension – Date: _____ |
| <input type="checkbox"/> Death – Date: _____ | <input type="checkbox"/> Teacher/Contract Ends – Date: _____ |
| <input type="checkbox"/> Retirement (Please complete questionnaire below) | <input type="checkbox"/> Leave of Absence-Medical |
| <input type="checkbox"/> Termination/Resignation - Date: _____ | <input type="checkbox"/> Leave of Absence-FMLA |
| <input type="checkbox"/> Other (attach explanation to this form) | <input type="checkbox"/> Leave of Absence-Personal |
| <input type="checkbox"/> Cancel Retiree Continuation – Date: _____ | <input type="checkbox"/> Reduction of Work Hours – # of Hours _____ Date: _____ |

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

Dependent Name(s)	Social Security Number(s)	Signature of Employee
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	Date <input type="text"/>
<input type="text"/>	<input type="text"/>	

Part 2 - 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 <input type="text"/>	Date <input type="text"/>	Signature of Person Making Election <input type="text"/>
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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; CBEET 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