

2025 Employment Termination Form



This form must be completed for **all terminations**.
 Fax this form (or forms) to 916-442-6927, Attn: Benefits
OR mail it to: The Episcopal Diocese of Northern California
 Attn: Benefits
 2394 Fair Oaks Blvd.
 Sacramento, CA 95825

Congregations and Institutions will be liable for costs associated with insurance that is not correctly canceled due to this form not being received within **30** days of the date of the employee's termination.

This is a fillable form. Click on the box you wish to edit. You may also print this form and complete it by hand.

Employee Information			
Congregation/ Institution Name: _____	Congregation/ Institution City: _____		
Employee Name Title: _____	Clergy/Lay: <input type="checkbox"/> Clergy <input type="checkbox"/> Lay		
First Name: _____	Date of Birth: _____		
Last Name: _____	Employee Address: _____		
Social Security Number: _____	City, State: _____		
Hire Date: _____	Zip Code: _____		
Termination Date: _____ <i>(If the employee is being terminated)</i>	Qualifying Event: _____		

Information for person being terminated other than employee			
Person to terminate: _____	Termination Date: _____		
Social Security Number: _____	Date of Birth: _____		
Relationship to Employee: _____	Qualifying Event: _____		

Check each plan the person is currently enrolled in	
<input type="checkbox"/>	Pension
<input type="checkbox"/>	Medical
<input type="checkbox"/>	Dental
<input type="checkbox"/>	Life/ADD
<input type="checkbox"/>	Supplemental Life
<input type="checkbox"/>	Spouse Supplemental Life
<input type="checkbox"/>	Long Term Disability
<input type="checkbox"/>	IRP (Short Term Disability - Lay only)

Check each plan to terminate	
<input type="checkbox"/>	Pension
<input type="checkbox"/>	Medical
<input type="checkbox"/>	Dental
<input type="checkbox"/>	Life/ADD
<input type="checkbox"/>	Supplemental Life
<input type="checkbox"/>	Spouse Supplemental Life
<input type="checkbox"/>	Long Term Disability
<input type="checkbox"/>	IRP (Short Term Disability - Lay only)

Signature	
Prepared by: _____ <i>(Printed Name)</i>	Preparer's Job Title: _____
Preparer's Signature: _____	Date: _____

For questions, or to submit this form, please email benefits@norcalepiscopal.org.