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
350 University Avenue, Suite 280
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:	☐Clergy ☐Lay
First Name:		Date of Birth:	
Last Name:		Employee Address:	
Social Security Number:		City, State:	
Hire Date:		Zip Code:	
Termination Date: *(If the employee is being terminated)*		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	
☐	Pension
☐	Medical
☐	Dental
☐	Life/ADD
☐	Supplemental Life
☐	Spouse Supplemental Life
☐	Long Term Disability
☐	IRP (Short Term Disability – Lay only)

Check each plan to **terminate**	
☐	Pension
☐	Medical
☐	Dental
☐	Life/ADD
☐	Supplemental Life
☐	Spouse Supplemental Life
☐	Long Term Disability
☐	IRP (Short Term Disability – Lay only)

Signature

Prepared by: *(Printed Name)*		Preparer's Job Title:	
Preparer's Signature:		Date:	

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