



NOTICE OF EMPLOYEE TERMINATION / LEAVE / REINSTATEMENT

(For pension terminations, please contact your pension carrier)

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<input type="checkbox"/> Group Insurance Certificate #			
Employer Name		Employee Name	
Employee's Current Address (Number, Street, Apt. Number)			
City/Town	Province	Postal Code	Daytime Phone

2

EMPLOYEE TERMINATION – GROUP INSURANCE

<input type="checkbox"/> Employee Terminated	Date (YYYY/MM/DD) _____	
<input type="checkbox"/> No Longer Eligible	<input type="checkbox"/> Less than 24 hours/week	<input type="checkbox"/> No Longer a Permanent Employee
<input type="checkbox"/> Other (Please specify) _____		

3

EMPLOYEE LEAVE OF ABSENCE / TEMPORARY LAYOFF

During a leave of absence or temporary layoff, an employee may remain insured for all benefits with the exception of the disability benefits, so long as premiums continue to be remitted. In order for coverage to be continued, CINUP must be notified **before** the commencement of the leave, **and** provided with a scheduled return to work date.

<input type="checkbox"/> Terminate all Coverage	Last Day of Work (YYYY/MM/DD) _____
<input type="checkbox"/> Continue all Coverage except Disability	Last Day of Work (YYYY/MM/DD) _____
Scheduled Return to Work Date (YYYY/MM/DD) _____	

Employer's Signature _____ Date _____

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NOTICE OF EMPLOYEE TERMINATION / LEAVE / REINSTATEMENT

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EMPLOYEE MATERNITY / PARENTAL / COMPASSIONATE CARE LEAVE

During a maternity, parental or compassionate care leave an employee may terminate all coverage, continue all coverage, or continue all coverage except for disability benefits. CINUP must be informed of the employee's choice before the beginning of the leave. If the employee decides to continue coverage during the leave, the benefits must be continued for the entire duration of the leave, so long as premiums continue to be remitted. CINUP must be notified of the scheduled return to work date before the beginning of the leave.

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- Terminate all Coverage Last Day of Work (YYYY/MM/DD) _____
- Continue all Coverage Last Day of Work (YYYY/MM/DD) _____
- Continue all Coverage except Disability Last Day of Work (YYYY/MM/DD) _____

Scheduled Return to Work Date (YYYY/MM/DD) _____

Note: Benefits are administered in accordance with applicable legislation.

REINSTATE EMPLOYEE'S COVERAGE

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Coverage may be reinstated provided the employee returns to work within 12 months of the termination date and we are notified in writing within 31 days of their return to work date. Coverage is effective on the return to work date, not the date of notification. Reinstated employees will be enrolled with all eligible dependents, beneficiaries, benefits, salary information, and coverage levels held immediately prior to termination of coverage. If changes are required, please complete and attach an Employee Change Request.

- 1) Reinstatement all Coverage Return to Work Date (YYYY/MM/DD) _____
 Information is unchanged from coverage held immediately prior to termination of coverage.
- 2) OR
 Employee Change Request is attached

Note: If the employee returned to work more than 12 months from their termination date, a new Enrolment Application must be completed.

Employer's Name _____

Employer's Signature _____ Date _____