COMPANY:_____
TERMINATION REPORT

Company:_____

Employee:_____ Date of Hire:_____

Rate of Pay $_____ per _____ Date of Termination:_____

Position:_____ Supervisor:_____

Employee was: ☐ Full-Time ☐ Part-Time ☐ Temporary

Termination was: ☐ Voluntary ☐ Lay-Off ☐ Discharge

Form or Action	Date Issued	Date Completed
Company Termination Letter or Employee Letter of Resignation		
Exit Interview		
Final Paycheck		
Final Paycheck Acknowledgement		
Form DE 2320: Unemployment Insurance Pamphlet		
Health Insurance Premium HIPP Information		
Notice of COBRA Rights		
Notice to Employee as to Change in Relationship		
Other:		
Attain Passwords on email, computer system		
Notify IT to disable all corporate accounts		

Items in bold are required by law

Required of employers of 20 or more employees

COMPANY:_____
EXIT INTERVIEW CHECKLIST

1. _____ Complete the Change of Status Form
2. _____ Collect Access Card(s) and keys
3. _____ Explain that health and dental insurance coverage will continue through end of month
4. _____ Present option for COBRA benefit and notify third party administrator
5. _____ Present Separation Notice explaining Unemployment Compensation
8. _____ Collect credit card(s)
9. _____ Collect company-owned portable equipment
10. _____ Revoke access privileges and passwords to electronic data

COMPANY:_____

NOTICE TO EMPLOYEE:
CHANGE IN RELATIONSHIP

Employee Name:_____ Social Security Number:_____

Your employment status has changed. The reason has been noted below:

Voluntary quit effective: _____

Reduction in Force effective: _____

Discharge effective: _____

Leave of absence effective _____. Return to work date is _____.

Change in status from employee to independent contractor effective _____.

Refusal to accept available work effective _____.

Notes: _____

_____

_____

Supervisor's Signature: _____ Date: _____

Employee Acknowledgment

I received a copy of this notice on _____ ____, 19____.

Employee's Signature: _____ Date: _____

This Notice is Pursuant to Provisions of Section _____ of the _____ Unemployment Insurance Code

COMPANY:_____

EMPLOYEE ACTION REPORT

Client Company: _____

Last Name	First Name	Initial	Employee No.	SS No	Date Originated

NEW CHANGES

	Present	Change To
Monthly Salary		
Hourly Rate		
Shift		
Organization Code		
Job Title		
LOA		
Other		
	☐ Exempt ☐ Non-Exempt ☐ Hourly	☐ Exempt ☐ Non-Exempt ☐ Hourly

REASONS FOR CHANGE (check all that apply)

☐ Annual Review – Rating
☐ Department Change
☐ Location Transfer
☐ Position Transfer (use for jobs that are a lateral or decrease in grade level)
☐ Termination
☐ Voluntary ☐ Involuntary
☐ Promotion (use for jobs that are an increase in grade level)
☐ Other

SALARY/WAGE HISTORY

Previous Salary/Wage _____ (amount) _____ (date effective) Date of Hire _____

Next Previous Salary/Wage _____ (amount) _____ (date effective)

HUMAN RESOURCES USE ONLY

New hire	Resignation	Discharge	Eligible for rehire?
Rehire	with notice	Reduction in Force	Yes
Recall	without notice		No
Return from LOA			

Address No. & Street	City	State	Zip	Date of Birth _____ Home Phone _____

APPROVALS

Supervisor	Date	Human Resources	Date	
Department Manager	Date	Other	Date	Employee Signature

COMPANY:_____

EXIT INTERVIEW

Employee: _____ Date: _____

Company: _____

We would appreciate your input regarding your employment at _____ Company. Please complete this form and return it to us. This is voluntary and any comments you provide will remain confidential.

1. How would you rate _____ Company overall as an employer? Why?

_____

_____

2. What improvements would you recommend?

_____

_____

3. Why are you leaving _____ Company?

_____

_____

4. Were you compensated fairly? Please comment.

_____

_____

5. How would you rate your supervisor? Please comment

_____

_____

6. Is there anything you would like to add?

_____

COMPANY:_____

COBRA QUALIFYING NOTICE

Date

From: Human Resources

To:

Re: Notice of Right to Elect to Continue the Company's Group Health Plan Coverage

If you are married, both you and your spouse should read this Notice and review the Election Form. If your spouse and/or any dependent child does not live with you, you must advise the Company immediately of his, her or their address(es) so we can provide them this Notice and Election Form.

Because of the Qualifying Event specified at the end of this Notice, coverage under the Company health plan for you (and your covered spouse or dependent children, if any) will end shortly. Federal law (known as COBRA) permits you, your covered spouse and dependent children to elect to continue your company's health plan coverage for a limited time. This coverage is called "continuation coverage" or "COBRA coverage." You (and your covered spouse or covered dependent child, if any) are sometimes called a "qualified beneficiary" in this Notice.

If you or your covered spouse or dependent child want COBRA coverage, complete the enclosed Election Form and return it to the Company within the election period described below (and specified on the Election Form).

Continuation coverage consists of the coverage under the Company's group health plan that you and other Qualified Beneficiaries had immediately before your Qualifying Event. If the Company health plan changes benefits, premiums, etc., continuation coverage changes accordingly. During open enrollment, each Qualified Beneficiary will have the same options under COBRA coverage as active employees covered under the Company health plan.

How to Elect to Continue Health Plan Coverage

You will be contacted by_____ regarding rights, forms and election procedures to continue your coverage under COBRA.

COMPANY:_____

COBRA Notice - Page 2

The election period ends 60 days after the date of the Notice you will receive from _____ or 60 days after the Company health plan coverage expires, whichever period is longer.

Premium for COBRA Coverage
You must pay the entire premium for your COBRA coverage. [Administrators or other designated authority] will advise you of your rates. The rates include a 2 percent add-on allowed by COBRA to cover administrative expenses. These rates are subject to change once a year as of the beginning of the "determination year" as indicated on the schedule.

Payment of Initial Premium for COBRA Coverage
Initial payment of premiums for COBRA coverage must be made on or before the 45th day after electing COBRA coverage. For example, Joe completes and mails his Election Form on May 15. Joe must make his initial premium payment on or before June 29.

The initial payment must include payment for the premiums for all prior months of continuation coverage. The premium for the current month must be made within 30 days of the first day of the month. For example, Sandy's employment terminated in September and her first day of continuation coverage is October 1. Sandy elects continuation coverage and makes her initial premium payment in December. Sandy's initial premium must include payment for coverage for October and November.

No claims under the group health plan incurred after the Qualifying Event will be paid until the applicable premium is paid. If the full initial premium payment is not made within the 45-day period, COBRA coverage for the affected Qualified Beneficiary will be canceled. If, for whatever reason, you received any benefits under the Plan during a month for which the premium was not timely paid, you will be required to reimburse us for the benefits you received.

Payment of Premiums after the Initial Premium
After the initial premium, your premium payment is due the first of each month for that month's COBRA coverage. There is, however, a grace period for late payment, which expires on the 31st day after the first of the month. If you don't make the premium payment within the 31-day grace period, your COBRA coverage will be canceled retroactive to the last full month for which premiums have been paid. If, for whatever reason, you received any benefits under the Plan during a month for which the premium was not timely paid, you will be required to reimburse us for the benefits you received.

If the payment received is less than the full premium by an insignificant amount, there will be a 30 day grace period to make up the difference. If the full premium is

COMPANY:_____

COBRA Notice - Page 3

not received by the end of the grace period, coverage will end as of the end of the month for which the full premium has been received.

Duration of COBRA Coverage

18-month maximum*.* Generally, when there has been a termination of employment or a reduction in hours that causes coverage to be lost, COBRA coverage for a Qualified Beneficiary begins the day after the Company- provided health plan coverage is lost, and continues for up to 18 months or begins as of the first day of the next month. See information below for this plan's rule. For example, Bob's employment terminates in January and his last day of the company health plan coverage is January 31, 2012. If Bob properly elects COBRA coverage, it begins February 1, 2012 and can continue up through July 31, 2013. This general rule, however, has important exceptions that either lengthen or shorten the 18-month period.

36-month period. COBRA coverage for your covered spouse or dependent child can incr. ease to up to 36 months from the date the 18-month period began if any of the following events occur during the 18-month period: former employee dies; the employee and spouse are divorced or legally separated; or, for the dependent child only, the dependent child loses status as a dependent under the Company health plan. You, your spouse, or any dependent(s) must notify us within 60 days in case of divorce or the dependent child ceasing to be eligible, or else the COBRA maximum period will remain 18 months.

36-month period if you become entitled to Medicare. If the former employee becomes entitled to Medicare before expiration of the 18-month COBRA coverage period (including before your employment with the company terminated), the COBRA coverage period for your covered spouse or dependent child(ren) is a period that ends 36 months after you become entitled to Medicare, or the 18-month coverage period described above.

29-month period for disabled qualified beneficiaries. If a Qualified Beneficiary (including you) is disabled, COBRA coverage for all qualified beneficiaries may continue for up to 29 months from the date the 18-month period would begin. The 29-month period applies only if the following conditions are satisfied: (1) the Social Security Administration determines the Qualified Beneficiary is disabled at the time of the qualifying event or within 60 days of when COBRA coverage begins; and (2) the Qualified Beneficiary provides the company a copy of the determination within the 18-month coverage period and not later than 60 days after the determination is made. The premium for COBRA coverage increases after the 18th month of coverage to 150% of the applicable premium for the disabled Qualified Beneficiary, as well as other Qualified Beneficiaries, if they are in the same rate band.

Early Termination of COBRA Coverage

COBRA coverage can terminate before the 18-month, 36-month or 29-month period described above expires. COBRA coverage for a Qualified Beneficiary terminates on the earliest of: the month for which the premium for the Qualified

COMPANY:_____

COBRA Notice - Page 4

Beneficiary's COBRA coverage is not timely paid; the date the company ceases to maintain any group health plan; after electing COBRA coverage, the date the Qualified Beneficiary becomes (a) entitled to Medicare or (b) covered by another group health plan that contains no exclusion or limitation for pre-existing conditions of the Qualified Beneficiary, or which exclusion or limitation does not apply due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If a Qualified Beneficiary is entitled to 29 months of COBRA coverage on account of disability, but is later determined not to be disabled, coverage ends with the first month beginning more than 30 days after that determination. For further information, please contact the Company's plan administrator:

Due to the following Qualifying Event, occurring on [date of termination], you may be eligible for COBRA coverage, all information regarding rights, rates and period of eligibility will to be provided by [Administrators or other designated authority] Your existing coverage ends as [date coverage terminates according to insurance contract], unless you elect COBRA coverage.

Qualifying Event: Termination of Employment

COMPANY:_____

Acknowledgment of Receipt of Notification of COBRA Rights

I hereby acknowledge that I have received notice of rights to continue health plan coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

I understand that I (and/or my spouse and dependent children) **must complete and submit the attached COBRA Election Form within 60 days of (1) the date of the notice from [Administrators or other designated authority] or (2) the loss of coverage (whichever is later)** in order to be considered for continuation of coverage. I further understand that all costs of continuation coverage will be at my expense.

_____ _____

Signature Date

_____

Print Name

If any of the individuals entitled to coverage under your plan do not reside at your address, please list those individuals and their current address(es) below so they may receive notification of their COBRA rights as soon as possible. Attach a separate page with additional names and addresses if necessary.

_____

Name

_____

Address

_____

City State Zip

_____

Name

_____

Address

_____

City State Zip

This form must be returned to:

_____

Representative

_____

Company Name

_____

Address

Direct question about your COBRA rights to:

_____

Representative

_____

Telephone

COMPANY:_____

STATE OF _____ AND WELFARE AGENCY
DEPARTMENT OF HEALTH SERVICES
THIRD PARTY LIABILITY BRANCH
HEALTH INSURANCE SECTION
Address:_____
City, State Zip: _____

NOTICE TO TERMINATING EMPLOYEES

The [State] Department of Health Services will pay health insurance premiums for certain persons who are losing employment and have a high cost medical condition. In order to qualify for the Health Insurance Premium Payment (HIPP) Program, you must meet ALL of the following conditions:

1. You must currently be on Medi-Cal.

2. Your Medi-Cal Share of Cost, if any, must be $200 or less.

3. You must have ail expensive medical condition. The average monthly savings to Mediaeval from your health insurance must be at least twice the monthly insurance premiums. If you have a Medi-Cal Share of Cost, that amount will be subtracted from your monthly health care costs to determine if paying the premiums is cost-effective.

4. You must have a current health insurance policy, COBRA continuation policy, or a COBRA conversion policy in effect or available at the time of application.

5. Your health insurance policy must cover your high cost medical condition.

6. Your application must be completed and returned in time for the State of _____ to process your application and pay your premium.

7. Your health insurance policy must not be issued through the [State] Major Risk Medical Insurance Board.

8. You must n be enrolled in a Medi-Cal related prepaid health plan, County Health Initiative, Geographic Managed Care Program, or the County Medical Services Program (CMSP).

NOTE: If an absent parent has been ordered by the court to provide your health insurance, you will not be eligible for the HIPP Program.

For more information you may call this toll free number, 1-800-952-5294, and follow the recorded instructions.

FOR PERSONS DISABLED BY HIV/AIDS

Under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, persons unable to work because of disability due to HIV/AIDS and are losing their private health insurance may qualify for premium payment assistance through the CARE Health Insurance Premium Payment (CARE/HIPP) Program for up to 12 months if they meet the following criteria:

COMPANY:_____

1. Have applied for Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), State Disability Insurance (SDI), or other disability programs;
2. Are currently covered by a health insurance plan (COBRA, individual or group), which includes outpatient prescription drug coverage and HIV-related treatment services;
3. Are not currently on the AIDS Drug Assistance Program (ADAP);
4. Have a total monthly income of no more than 250 percent of the current federal poverty level and;
5. Will be eligible for the Medi-Cal/HIPP or a County Organized Health System (COHS) HIPP Program by the end of the 12-month coverage period.

For additional information on CARE/HIPP, You may call: _____

AIDS Hotline
_____ (English)
_____ (Multi-Language)

COMPANY:_____
FINAL PAYCHECK WORKSHEET

Employee:_____ Date:_____

If this separation is voluntary, the final paycheck must be issued on the final date of employment unless the company was given less than 72 hours notice. In such cases, the employer has up to 72 hours to pay the employee. If this separation is involuntary, the final paycheck must be issued on the employee's last day of work.

Final paycheck is due on: _____

Wages:

Regular hours x 1.0 x Hourly Rate =	_____
Overtime hours x 1.5 x Hourly Rate =	_____
Double time hours x 2.0 x Hourly Rate =	_____
TOTAL	_____

Accrued Vacation Pay:

Accrued Vacation - Used Vacation x Hourly Rate =	_____

Other Pay, if applicable:

_____	_____
_____	_____
TOTAL WAGES DUE	_____
Total Regular Deductions:	_____

Other Deductions, if applicable:

_____	_____
_____	_____
TOTAL DEDUCTIONS	_____

Final Paycheck: Check # _____ _____

COMPANY:_____
FINAL PAYCHECK ACKNOWLEDGMENT

Employee:_____ Date: _____

This is to acknowledge that I have received my final paycheck from _____ Company.

The check is in the amount of $_____.

To the best of my knowledge, _____ Company does not owe me any additional money.

_____ _____

Signature of Employee Date Signed

COMPANY:_____

TERMINATION AGREEMENT

This is to certify that I do not have in my possession nor have I failed to return, any documents, data, customer lists, customer records, sales records, or copies of them, or other documents or materials, equipment or other property belonging to the Company.

Further I agree that in compliance with the Employee Proprietary Information Agreement, I will preserve as confidential all trade secrets, confidential information, knowledge, data, or other information relating to products, processes, know how, designs, formulas, test data, customer lists, or other subject matter pertaining to any business of the Company or any of its clients, customers, consultants, licensees or affiliates.

_____ _____

Signature Date

COMPANY:_____
EMPLOYER PROPERTY RETURN AGREEMENT

Employee:_____ Date:_____

I acknowledge that I have received from [Company], the items listed below. I understand that if I quit my employment with [Company] these items are due by my final day of employment. Likewise, if [Company] should terminate my employment, these items are due at the time of termination. [Company] may request the return of the items at any time and I agree to their return upon that request.

	Item	Approximate Current Value
1.		$
2.		$
3.		$
4.		$
5.		$
6.		$

I understand that all of the times listed above remain the sole property of [Company]. By signing this agreement, I understand I am obligated for the value of the item(s) not returned promptly after termination.

_____ _____

Employee's Signature Date