Diocese of Covington

Employee Benefits Office - Health Insurance

Delete Notice

Use this form to notify the Benefits Office of an employee to be removed from the Diocesan Medical Group

Parish/School/Institution _____

Employee Name _____

Employee Soc. Sec. No. _____

Termination Date _____
month day year

Coverage End Date * ____ / 30 / ____
month day year

* - Coverage will end on the last day of the termination month unless noted otherwise.

Reason the employee removed from the medical group at this location (check one):

_____ Employee requests removal; still employed (employee must sign below)

_____ Employee terminating employment

_____ Employee working less than required minimum hours (15hrs/week)

_____ Employee transferring to another location within the Diocese
Transferring to _____

_____ Other (explain) _____

EMPLOYEE SIGNATURE (only required if coverage ceases; but employment continues)

By signing below, I certify that I am voluntarily declining medical coverage and that I have not received any compensation, renumeration, stipend, reward or any other type of payment, credit or benefit in exchange for the declination.

_____ _____
Employee Signature Date

EMPLOYER AUTHORIZATION

_____ _____
Pastor or Principal Date

Mail to: Benefits Office, 1125 Madison Avenue, Covington, KY 41011-3115
or
FAX to: (859) 392-1589

Contact: Liz Champ at (859) 392-1554 or LChamp@CovDio.org

Credit can only be given for the current month that the information is received in this office.