

TERMINATION OF BENEFITS / EMPLOYMENT NOTICE

DCSS 0114 (08/21/2016)

EMPLOYER: _____ DATE: _____

EMPLOYEE: _____ COUNTY: _____

SSN: _____

DOB: _____

PARTICIPANT NUMBER: _____ PHONE: _____

INSTRUCTIONS: Use this form to report termination of employment or benefits of an employee for whom you have a requirement to withhold support and/or provide health benefits.

Termination of: Employment Health Benefits Both

DATE OF TERMINATION - BENEFITS		REASON FOR TERMINATION	
		<input type="checkbox"/> Temporary Lapse - date coverage is to resume _____ DATE <input type="checkbox"/> Permanent Termination	
COBRA HEALTH INSURANCE AVAILABLE?			
<input type="checkbox"/> NO <input type="checkbox"/> YES, coverage thru: _____ DATE			
DATE OF TERMINATION - EMPLOYMENT		REASON FOR TERMINATION	SUBJECT TO REHIRE?
			<input type="checkbox"/> NO <input type="checkbox"/> YES
LAST KNOWN HOME ADDRESS (Street address, City, State, Zip code)			TELEPHONE NUMBER
NEW EMPLOYER'S NAME (if known)			TELEPHONE NUMBER
NEW EMPLOYER'S ADDRESS (if known - Street address, City, State, Zip code)			

CERTIFICATION OF RECORD

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

SIGNATURE

DATE

PRINTED NAME

TITLE