Health Risk Services Inc.

Providing Your Innovative Benefits Solutions

Employer - Termination Form

Send to:
Email: claims@healthrisk.ca
Fax: (403) 236-9420
Mail: 50, 12221 - 44th Street SE
Calgary AB T2Z 4H3

Plan Administrator: Please complete and sign section 1. Complete Section 2 and return to Health Risk Services.

1. GROUP INFORMATION

Company Name:		**Group Number:**
Plan Administrator Name:	**Signature:**	**Date Signed:**

2. EMPLOYEE TERMINATION

Client ID	Last Name	First Name	Reason for Termination (death, dismissal, insufficient hours, resignation, retirement, strike etc…)	Last Day of Coverage mm/dd/yyyy

Reason for Termination: If an employee is choosing to opt-out of coverage due to spousal coverage, the employee should complete and submit an Employee Change Form. You do not need to include them in the Employee Termination section on this form.

Last Day of Coverage: Terminated employees will have coverage until 11:59:59pm on the last day of coverage.

Billing: Premiums will not be billed for the month if the termination is dated and received within the first 3 days of the month.