ARCHDIOCESE of NEW YORK

______________________________ ______________________________ __________

Employee Name *(Print)* Employer (Institution) Institution-Div. #

NOTICE OF BENEFIT STATUS DUE TO SEPARATION FROM EMPLOYMENT

The following is a summary of your benefit coverage status as of your separation date:__________________
(insert date)

GROUP MEDICAL COVERAGE

IMPORTANT NOTICE: ***If your institution /employer closes or ceases to participate in the Archdiocese of New York's Health Benefit Plan for any reason, you are not eligible for Continuation of Benefits Coverage.***

If you are not covered as an employee or continue under another group health plan, you have the option to continue your group medical coverage(s) for up to thirty-six (36) months.

Covered dependents are eligible for continuation of group medical coverage for up to 36 months in the event of the employee's death; change in dependent status (i.e. divorce, legal separation or dependent child reaches the age limitation); dependent would otherwise lose coverage when employee becomes eligible for Medicare. If you or your spouse, and/or dependent children wish to elect continuation of coverage, you must notify **your local administrator** in writing within 60 days from the date you would lose coverage as a result of a qualifying event or 60 days from the date you receive this notice, whichever is later. In addition, you must pay the premiums within 45 days from the date of election of continuation of coverage. Subsequent premiums are due on the first of each month. All premium payment checks should be made payable to the ***Archdiocese of New York*** and should be sent to:

Employee Benefit Connections
1011 First Ave, Suite 1654
New York, NY 10022

Your current single, family, or employee plus one medical coverage(s) will terminate on ___________________________, unless you elect one of the following options:

Do you elect continuation of your group medical coverage:

Employee:	Yes_______	No_________
Spouse:	Yes_______	No_________
Dependent Child(ren)	Yes_______	No_________

If you have elected yes, **you must complete** and sign the **Group Health Continuation Election Form**, which will be mailed under separate cover.

____ ______________
Authorized Employer Representative's Signature Date

____ ______________
Employee/Member Signature Date

____ ______________
Spouse's/Dependent's Signature Date

NOTE: ORIGINAL OF THIS FORM SHOULD BE GIVEN TO EMPLOYEE, MAKE A COPY FOR EMPLOYEE'S FILE.

______________________ ______________________ __________

Employee Name *(Print)* Employer (Institution) Institution-Div. #

GROUP LIFE INSURANCE

Your current group life insurance with Hartford Life will terminate on your last day of employment ____________________.
(insert date)

You may continue your life insurance by electing one of the following options within 31 days following the date your coverage terminates.

Portability Option:

Terminating employees who have not reached the Defined Retirement Age (in accordance with the 1983 amendments of the United States Social Security Act) would be eligible to apply for continuation of life insurance under the Portability Option at group rates.

Conversion Option:

Conversion is available upon termination of coverage subject to plan limitations. Please contact **your local administrator** for additional information.

To secure Applications for Portability or Conversion, you may call Hartford Life at **(877) 320-0484**.

GROUP LONG TERM DISABILITY INSURANCE *(if applicable)*

Your current LTD insurance will terminate on your last day of employment ______________________. There is no conversion privilege for this benefit.
(insert date)

FLEXIBLE SPENDING ACCOUNT *(if applicable)*

If you have an accrued amount in your Flexible Spending Account as of your date of separation, you can be reimbursed for medical/dependent expenses incurred prior to your separation date. You must submit an FSA claim form and copies of supporting documentation directly to P&A Group.

RETIREMENT PLAN

For information concerning pension benefits, please send written request to the **Archdiocese of New York, Pension Department, 1011 First Avenue, New York, NY 10022**. All inquiries must include your name, social security number, the name and address of the local employer institution where you were employed (list all institutions if more than one), and signature of the employee.

______________________________ ______________________________

Authorized Employer Representative Signature Date Employee Signature Date

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