Notice of Employee Termination

To: GBA Insurance Trust COBRA Department

From: _____(Employer)

Date: _____

As required under the rules regarding reduced premiums for COBRA coverage under the American Recovery and Reinvestment Act (ARRA), we are notifying you of the following employee termination:

Employee Name: _____

Employee SSN: _____

Date of termination from employment: _____

Employee Address: _____

_____

Reason for termination. (Note: read the IRS Guidance below before completing this section.)

> **IRS Guidance on Involuntary Termination:** *For COBRA purposes only,* involuntary termination means a severance from employment due to the employer's exercise of its unilateral authority to terminate an employee's employment. The termination must not be at the employee's implicit or explicit request, and the employee must be willing and able to continue working. However, termination may be involuntary if the employee has good reason to resign due to actions by the employer which cause a material negative change in the employment relationship. This may include, for example, an employee who resigns due to an employer-initiated reduction in work hours, or a change in job location. (But a reduction in hours that causes a loss of health coverage is not itself an involuntary termination unless the employee resigns as a result of the reduction in hours.) Whether or not a termination is involuntary is decided on the basis of all the facts and circumstances. Some typical scenarios are described below.

Based on these principles, was the employee involuntarily terminated?

☐ **YES.** If this box is checked, check the applicable box below:

- ☐ Terminated for cause. If this box is checked, was the employee terminated for gross misconduct?
  - ☐ Yes. Explain:_____
  - ☐ No.
- ☐ Reduction in force or layoff.
- ☐ Employee elected severance package, where employer announced that employee was at risk for layoff or reduction in force if package was not accepted.
- ☐ Resignation in lieu of dismissal or layoff.

☐ Retirement in lieu of dismissal or layoff.

☐ Failure to return to work following leave of absence because medically unable to work.

☐ Other:_____

☐ **NO.** Employee terminated voluntarily.

ATTESTATION OF EMPLOYER:

I attest that the information on this form is true and correct to the best of my knowledge, and that I have made my determination as to the voluntary/involuntary nature of the employee's termination, as indicated above, in good faith. I understand that this determination will form the basis of an eligibility determination for COBRA coverage at reduced rates under the ARRA, and that claiming a payroll tax credit under the ARRA with respect to an employee who was not terminated involuntarily, may lead to significant tax penalties.

Employer_____
By: _____
Title: _____
Date: _____