TERMINATION OF BENEFITS / EMPLOYMENT NOTICE

DCSS 0114 (08/21/2016)

DATE:

EMPLOYER:

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 ☐ Temporary Lapse - date coverage is to resume _____ (DATE) ☐ Permanent Termination	
COBRA HEALTH INSURANCE AVAILABLE? ☐ NO ☐ YES, coverage thru: _____ (DATE)		
DATE OF TERMINATION - EMPLOYMENT	REASON FOR TERMINATION	SUBJECT TO REHIRE? ☐ NO ☐ 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