_____

Facility Name

Change in Hours Form

Employee Name _____

Employee Address _____

Employee Date of Birth _____ Employee SSN _____

Employee # _____ Employee Job Code _____

**Event**

| | |
|---|---|
| Termination | Date _____ |
| Reduction of Hours | Date _____ |
| Increase to Full Time | Date _____ |
| Leave of Absence | Date _____ |
| Return from Leave of Absence | Date _____ |

Was the event selected above: _____ Voluntary _____ Involuntary

*Benefits**:** (please check and complete) The employee is currently participating in our benefits program and understands that insurance will be effective through the month of termination/change in status. Premiums for that timeframe will be deducted from the final check or the employee will make arrangements to pay the facility. COBRA notification is a federal requirement and completion of this form in a timely manner is imperative so we meet these guidelines.*

We have reviewed this form together and understand the procedure and timing of benefits termination obligation to pay for benefits.

Administrator/Facility representative: _____ Date_____

Date Faxed to Payroll 319-362-9750 _____

Date Faxed or Emailed to TrueNorth 319-862-0609 _____

trueadvocate@truenorthcompanies.com

Within 48 hours from the time of notification of the above event, fax this form to both TrueNorth and Payroll or HR at HCI. (If 2 week notice is given please notify after notice is given and not 48 hours from official termination date.) As an employee gives notice of termination, reduces hours below full time status as defined by the facility handbook (30 hours for benefits) increase hours to Full Time status, moves to PRN status, goes on FMLA or unpaid leave (send the form at the beginning and the end of leave) or as an employee is placed on Workers Compensation.

Revised 12/2022