60-DAY OFFER FORM

60

Complete/Complete Plus Eligibility Statement

Please note that in order to be eligible for the GUARANTEED Complete or Complete Plus plan, enrollees must be employee or retiree of an endorsing Canadian hospital.

New hires: part-time/casual/contract/temp	Full-time retiring from the hospital
Full-time transferring to part-time or casual	Full-time permanently laid-off from hospital
Full-time transferring to temporary or contract	Losing hospital benefits at age 65

Enrollees have 60 days from the first of the occurrences listed above to apply for the GUARANTEED Complete or Complete Plus plan for the employee, their spouse and eligible dependants. To confirm eligibility for the 60-day offer under the Health Care Providers Group Insurance Plan™, the following must be submitted with the employee's enrollment:

A copy of the employee's hospital offer letter or other official documentation outlining their employment status, retirement, or lay-off and the start date of the occurrence.

– OR –

This 60-day offer form completed, signed and dated by an authorized human resources professional at their hospital of employment.

To Be Completed By Human Resources Personnel Only

Employee Name: _____ (First Name/Last Name)

Hospital: _____ (Hospital Network/Site Name)

New Employee: ☐ Part-Time ☐ Casual ☐ Temporary ☐ Contract

Start Date: _____ (MM/DD/YYYY)

Full-Time Transfer To: ☐ Part-Time ☐ Casual ☐ Temporary ☐ Contract

Transfer Date: _____ (MM/DD/YYYY)

Full-Time Employee: ☐ Retiring ☐ Permanently Laid Off ☐ Losing Benefits @ Age 65

Occurrence Date: _____ (MM/DD/YYYY)

_____ (HR Initials) By initialing, I certify that the above listed employee is losing their benefits after having been actively employed immediately prior to the occurrence dated above.

By signing and dating this 60-day offer form, I certify that the information detailed on this form regarding both the employee and corresponding information regarding their employment/benefits status with our organization is correct.

Authorized HR Staff Name: _____ (Please Print)

Authorized HR Staff Signature: _____ (Please Sign)