The Episcopal Diocese of California
1055 Taylor Street, San Francisco, CA 94108
tel 415-673-5015; fax 415-673-4863, email sarahc@diocal.org

INSTRUCTIONS FOR TERMINATION PAPERWORK FOR THE DIOCESE OF CALIFORNIA'S BENEFITS & PAYROLL

1) **Termination Notice:** Completed by employer and returned to the Payroll & Benefits Office prior to final pay date.

2) **Extension of Benefits Paperwork:** The Diocese of California **does not have COBRA** obligation under federal laws and regulations. However, we provide an Extension of Benefits for medical and/or dental for our employees and their eligible dependents. Page 3 of this packet outlines the basic provisions of this policy.

   a. **Employer** complete the top section of Dental Continuation Election Form (details of coverage and premium listed on recent benefit invoices)

   b. **Employer** provides the Dental Continuation Election Form to employee on date of termination.

   c. **Employee** has 30 days from termination date to enroll in Dental Continuation Plan.

   d. **Canonically Resident Clergy contact Diocesan Benefits Office.**

3) **Salary Continuation Paperwork:** Unemployment is provided to employees that were on record as working at least 20hr/week (to verify that your terminating employee received Salary Continuation benefits review your most recent benefit invoice from DioCal)

   a. **Employer** provides Salary Continuation information and enrollment form to employee

   b. Inform employee that there is no unemployment benefit available through the State of California.

   c. **Employee** has 30 days from termination date to apply for benefits

   d. The Salary Continuation plan manager will contact employer to verify application details, please respond in a timely manner.

   e. If former employee was paid through the Diocese of California's payroll service we will handle the payment of benefits. Otherwise we will contact you to arrange for payment to former employee and reimbursement from DioCal.

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TERMINATION NOTICE TO DIOCESE OF CALIFORNIA

Today's Date: ______________________ Prepared By: _____________________________________

Employing Entity: ____ Parish Code: _______________

Employee Name: ____ Last Day Worked: ____________

An employee who is discharged must be paid all of his or her wages, including accrued vacation, immediately at the time of termination. Labor Code Sections 201 and 227.3) If the final day of work falls on payday you may process final check with regular payroll see option 2 below

☐ Remove Employee from Benefits (employees working 20+ hrs./wk have benefits)

Effective Date for cancellation of employer provided benefits:_______________
(coverage continues to the final day of the month indicated. For example Jan 1 or Jan 16 = Jan 31st cancellation of coverage)

We verify that Salary Continuation information was provided to terminating employee on the date of: _____________

We verify that Medical Continuation information was provided to terminating employee on the date of: ___________

The former employee has 30 days from termination date to apply for Salary or Medical Continuation

☐ Remove Employee From Diocesan Payroll

1) To issue a manual check on day of termination contact the. Please know the total gross pay owed which includes the value of any accrued vacation benefit. We will provide you with the appropriate tax deductions and net pay of the final check you are to issue to employee. Fax a copy of the final check along with this notice to the Diocesan Payroll Office: 415-673-4863

OR if final day of work falls on pay date you may process final check with regular payroll

2) Process final paycheck with regular payroll on this date: _______ 15th or ______ 30th/31st
Use the timesheet to indicate any amount of pay to be added (+) or deducted (-) from the final paycheck (ie: salary adjustment, accrued vacation)

Signature of Authorized Agent: ____

Contact Phone: ________________________**Contact Email:**____________________

Termination Notice should be returned by fax to 415-673-4863 or email to sarahc@diocal.org
Medical & Salary Continuation forms to be given to terminating employee

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Extension of Medical and Dental Coverage

**(NOT TO BE USED BY CANONICALLY RESIDENT CLERGY
PLEASE CALL THE BENEFITS OFFICE FOR CLERGY FORMS & INFORMATION)**

The Diocese of California **does not have COBRA** obligation under federal laws and regulations. However, we do provide an Extension of Benefit option for our employees and their eligible dependents. The following outlines the basic provisions of this policy.

1. Medical Continuation does not apply to canonically resident clergy. Cleric should contact DioCal Benefits Office for information & forms to purchase medical, dental, life & EAP coverage.

2. Extension of Medical Benefits will be provided through The Episcopal Church Medical Trust. ECMT will send instruction directly to you. If you have questions on extension of medical benefits please call ECMT client services 800-480-9967.

3. Cigna dental coverage may be continued through the Diocese for a maximum of 36 months. Coverage must be in place at the time of the termination of your employment. Only those dependents covered at the time of termination may be remain on the plan as long as primary member continues coverage.

4. **The terminated employee pays the cost of the coverage** effective the first of the month following date of termination. For example: if your employment ends on April 12 your employer will continue your coverage until April 30, then you will assume responsibility for coverage effective May 1.

5. The Former employee must complete the Dental Extension of Benefits form and submit first month premiums within 30 days of termination date. Failure to comply with this provision will end your eligibility for continuation of coverage.

6. **The Diocese will send invoices on a monthly basis. If premiums are not paid each month, coverage will be terminated retroactive to the last day of the period for which premiums have been received**.

7. You may cease coverage early by notifying the diocesan administrator in writing of your decision. **Notice must be in writing.** Coverage will be terminated on the last day of the month requested.

8. All correspondence about the continuation of Cigna dental policy must be addressed to:

   Diocese of California Benefits Administrator
   1055 Taylor Street
   San Francisco, CA 94108
   Email: sarahc@diocal.org

9. For questions, please call, fax or email:
   Sarah Crawford, Benefits Coordinator
   Ph: 415-869-7805
   FAX 415-673-4863
   Email sarahc@diocal.org

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DENTAL CONTINUATION ELECTION FORM – FOR LAY EMPLOYEES ONLY

**(NOT TO BE USED BY CANONICALLY RESIDENT CLERGY
PLEASE CALL BENEFITS OFFICE FOR CLERGY FORMS & INFORMATION)**

Notice Date: ________________________________ Prepared By: __________________________

Former Employer (entity name & city) :____

Termination Date (continuation of coverage begins on the 1st of month following term date): ______________________________

Dear (employee name) ____:

Former employees are eligible to continue their current medical / dental benefits at their own expense for up to 36 months. The Episcopal Church Medical Trust will send information & instruction regarding your extension of medical. If you wish to continue dental insurance please read on.

To continue Cigna dental coverage, you must respond with payment for your first month's insurance premiums within **30 days from your termination date**. You will be billed for your monthly premiums thereafter. Your monthly payment is due by the first of each month, *whether or not you receive a bill*.

If you wish to continue dental coverage, please read the instructions (previous page) and the statement below, sign it, then **send this letter and a check to cover one month's premium payable to "The Diocese of California" attn: Benefit's Office, 1055 Taylor Street, San Francisco, CA 94108.** Thereafter we will send you a monthly invoice with remittance envelope for payment of premiums.

I wish to continue Cigna dental coverage at my own expense, and have enclosed payment to cover the cost of my first month's premiums. I understand that the Diocese must receive this notice and payment within **30 days of my termination date**. I further understand that future payments will be due on the first of each calendar month.

Yes, I accept continued Dental Coverage and will assume the monthly premiums:
Single $61.59 Dual $113.05 Family $166.05

Signed: ____ Date: ______________________

Name: _____________________________________Social Security #: ________________________

Address: ____

City: _________________________________ State: ______________________ Zip: _____________

Phone: ____________________ Fax: _______________________ Email:________________________

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Salary Continuation Benefits Program (for lay & clergy)
Unemployment Benefits are not available through State of California

PURPOSE:
To provide full-time (20hours or more a week) lay and clergy employees a Salary Continuation Benefits Program intended to benefit those individuals whose employment within the Diocese of California is discontinued for reasons beyond their control.

ELIGIBILITY:
Salary Continuation Benefits are payable to lay and clergy employees working 20 hours or more a week, and continuously employed for a minimum of 90 days, who qualify for benefits for the reasons described below.

BENEFITS:
The amount of Salary Continuation Benefits for eligible employees will be determined by length of service and average weekly salary. Eligible employees will earn one week of Salary Continuation Benefits for every calendar month employed (starting with their date of employment to a maximum of 26 weeks. Eligible employees will be entitled to a weekly benefit amount equal to 40% of their average weekly salary for the actual period of employment up to 26 weeks immediately preceding separation of employment, to a maximum weekly benefit of $555.00.

CLAIMS ADMINISTRATION:
Determination of claimant's eligibility and approval of payment of benefits are the responsibility of a third party Claims Administrator, appointed by the Personnel Practiced Commission which serves as Trustee for the Salary Continuation Benefits Program. The Claims Administrator is responsible for determining eligibility for benefits at the time a claim is first presented by the employee. Eligibility for benefits will cease when claimant gains employment.

Eligibility for continuing weekly benefits is determined by a bi-weekly audit conducted by the Claims Administrator.

Either the employee or employer may appeal eligibility determinations within 15 days of such determination being communicated in writing to both parties. Such appeals will be referred to an impartial Arbitrator experienced in unemployment benefits practices and procedures who will hear testimony by both parties in order to reach a final decision.

A details explanation of Claims Procedures follows.

I. QUALIFICATION – Eligible employees may qualify for weekly Salary Continuation Benefits if they

A) Quit for a job related cause because of:
   1) Threat of safety in the workplace
   2) Reduction in working hours of 20% or more
   3) Work-related stress if substantiated by medical documentation
   4) Proven discrimination in the workplace based on that individual's race, color, sex, national origin, ancestry, or physical handicap
   5) Proven sexual harassment provided the individual has taken reasonable steps to preserve the working relationship
   6) Required resignation because of change of clergy leadership
   7) Completion of non-renewable fixed-term contract

B) Were improperly discharged, provided:
   1) Discharge is without sufficient documented warning (at least one verbal and one written warning, except for act of gross misconduct)
   2) Discharge is solely based on employee's unavoidable absence or tardiness. Unavoidable absence or tardiness includes: a) death in the immediate family, b) unlawful detainment, c)

hospitalization for treatment of an emergency or life threatening condition, d) due to a summons to serve jury duty or a court subpoena

3) The employee is not offered similar or same position at similar or same rate of pay upon returning from authorized leave of absence

C) Were discharged for lack of work resulting from
  1) Reduction in force
  2) Elimination of position

II. DISQUALIFICATION – Claimant will be denied weekly Salary Continuation Benefits should one or more of the following conditions occur:

A) Discharge for gross misconduct, such as deliberate disregard for the well being of the employer and/or employees.
B) Job abandonment defined as unreported absence of three (3) or more days
C) Failure to Comply with employer's wishes that employee seek professional treatment for substance abuse
D) Employee willfully made a false statement or representation, with actual knowledge of the falsity, or withheld a material fact in completing employment application or in filing a claim for Salary Continuation Benefits
E) Voluntarily quit without work-related cause
F) Voluntary retirement
G) Failure to comply with the rules and policies of the employer as established by the employer's personnel policy.
H) Temporary lack of work due to established vacation, holiday or recess periods, provided reasonable assurance of re-employment is given prior to said period
I) Individual becomes unable to work due to a physical or mental illness or injury unrelated to his/her job

III. FILING A CLAIM

A) Separated employee may file a claim for Salary Continuation Benefits by completing a Salary Continuation Benefits Claim form within 30 days of the official date of separation from the Diocese
  1. Claim Form can be obtained from the Administrator's Manual in the employer office or online at www.diocal.org/admin/
  2. Completed forms must be submitted to the Claims Administrator at the following address and post-marked within 30 days of Separation:

     WageWorks - ATTN: Wendy Kipperman-Burns
     10375 Baldev Court, Mequon WI 53092
     Phone: 262.236.1014 Fax: 866.784.6032
     Email: wendy.kipperman-burns@wageworks.com

  3. The Claims Administrator will render a benefits decision within 10 working days of receipt of the claim form

IV. FILING AN APPEAL

A. Disputed benefits decisions may be appealed by either party within 15 days of the date indicated on the notice of decision.
  1. Such appeals must be submitted in writing by the appellant to the Claims Administrator at the above address
  2. Upon receipt of the appeal a Notice of Hearing will be issued to the claimant and the employer by an Arbitrator
     a) Attendance at the hearing at the time and date indicated on the Notice of Hearing is mandatory
  3. The decision of the Arbitrator is final

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BENEFITS CLAIM FORM
Salary Continuation (unemployment)

Claimant's Name:______________________________SS#: ______________________

Mailing Address: ____
____
____

Telephone: _______________________ **Email**: _______________________________

Job Title / Description: ____

Dates of Employment First day:__________________ to Last day:___________

Employing Entity Name: ____

Employer Address: ____
____
____

Name & Title of Immediate Supervisor: _________________________________
(Supervisor will be contacted to verify Salary Continuation claim form)

Supervisor's Contact Information: Phone #: (_____)________________________

Fax #: (_____)__________________ Email:_______________________________

Are you able to work, available for work and actively seeking work?
(circle one) **YES** **NO**

Did you voluntarily quit your job?
(circle one) **YES** **NO**

Were you discharged or fired for reasons other than lack of work?
(circle one) YES* NO if yes, please explain: _________________________
____
____
____

Employee's Signature:____________________________________Date: ____________

Return completed claim form to:
WageWorks - ATTN: Wendy Kipperman-Burns
10375 Baldev Court, Mequon WI 53092
Phone: 262.236.1014 Fax: 866.784.6032
Email: wendy.kipperman-burns@wageworks.com