HEALTH CARE PROVIDERS 60-DAY OFFER FORM

60

This offer form is for:
~New Part Time & Casual hires
~Full Time transferring to Part Time or Casual
~Full Time retiring from the hospital
~Full Time permanently laid off from hospital
~Full Time losing Hospital Benefits @ age 65

You have **60 days** from the first of the above occurrences, on or after the initial implementation date of the plan into the hospital to apply for ***GUARANTEED*** coverage at the **COMPLETE** level for you, your spouse and your eligible dependents

To confirm your eligibility for this 60 day offer of guaranteed COMPLETE coverage under the HCP Group Insurance Plan, you must submit with your application either:

A. copy of your hospital offer letter or other official document outlining your offer of employment, retirement, or layoff, and in particular indicating your start date of the occurrence at or from the hospital. **OR**
B. this form completed by an authorized Human Resources professional at your hospital

To be completed by Human Resources personnel only:

NEW EMPLOYEE PART TIME ☐ CASUAL ☐ TEMPORARY ☐ CONTRACT ☐
FULL TIME TRANSFER TO PART TIME ☐ CASUAL ☐ TEMPORARY ☐ CONTRACT ☐

I certify that _____ started his/her current employment for
(first name, last name)

_____ on _____.
Hospital name dd/mm/yyyy

FULL TIME EMPLOYEE

RETIRING ☐ ***PERMANENTLY LAID OFF*** ☐ ***LOSING HOSPITAL BENEFITS AT AGE 65*** ☐

I certify that _____ is retiring, being permanently laid off, or losing their Full Time
(First name, Last name)

Benefits at age 65 on _____ after having been actively employed immediately prior to this
dd/mm/yyyy

occurrence at _____
Hospital

_____ _____
Name of Authorized Human Resources Staff Member (Please print) Signature of Authorized Human Resources Staff Member