THE ROMAN CATHOLIC
ARCHDIOCESE OF ATLANTA

Employment Termination Procedures

Voluntary Resignations

A written resignation is required from each employee who voluntarily resigns. An exit interview should be scheduled on or near the last day of employment. The exit interview form should be completed by the interviewer allowing the departing employee to provide feedback related to their experience with their direct supervisor, benefits provided or other information as appropriate.

Extension of Benefits/ Termination Notice

Each full-time employee must be given extension of benefits information on the last day of employment. There is a 30 day window of opportunity for employees to elect continuation of benefits after which time the employee's application may be rejected. Sample extension of benefits letters are included in the Full-time Termination Packet. All full-time employees should receive a letter and the appropriate attachments which are listed in the letter. In addition, employees should receive a Notice of Continuation form to convert life insurance.

The termination checklist should be completed with all of the required documentation. Please forward all required documents to Human Resources. If the employee is transferring to another location within the Archdiocese this information should be noted.

Involuntary Terminations

The procedures below should be followed for all terminations except for voluntary resignations. Involuntary terminations include all terminations for cause, position eliminations, non-renewals of contracted (school) employees or cases where resignation is requested.

The policy of the Archdiocese of Atlanta requires that every termination be reviewed and approved by the Director of Human Resources. As required by Catholic Mutual Insurance Company for employment practices liability coverage, the Director of HR will present each termination to legal counsel for approval.

It is important that managers communicate to employees areas of deficiency. Memos to the personnel file should memorialize discussions regarding unsatisfactory work performance. In some instances a final written warning is appropriate which should be signed by the employee and placed in the personnel file. Sample warnings are available and can be provided by the HR Department. It is suggested that all disciplinary meetings include the manager or supervisor and one other individual in addition to the employee.

All pay and benefits will typically cease on the day of termination. Advance notice of termination is not required. Position eliminations are an exception to this general rule and require, according to policy, severance pay based on years of service including continuation of health benefits during the severance period for full-time employees only. See the Extension of Benefits and Termination Notice procedures above for additional required procedures.

2401 Lake Park Drive, S.E. • Smyrna, Georgia 30080-8862
404-920-7800 • Fax 404-920-7801 • archatl.com

THE ROMAN CATHOLIC
ARCHDIOCESE OF ATLANTA

TERMINATION CHECKLIST

Check one:	☐ Full-time	☐ Part-time	☐ Temporary
Employee Name:		**Date of Termination:**	
Location:		**Department:**	

PERSONNEL *(Initial on line)*

_____ Letter of Resignation from Employee
_____ Exit Interview
_____ Termination Notice
_____ Lay Welfare Repayment Memo (if applicable)
_____ Notice to Georgia Child Support Enforcement Office (if applicable)
_____ Separation Notice (if applicable, Catholic Charities employees only)
_____ Send Records Checklist to employee's supervisor to ensure return of digital and paper records.
_____ Notify the IT Department and the Office of Archives and Records of the departure immediately.
_____ Property of Archdiocese collected (access card, keys, laptop, cell phone)

Please list each item collected:

BENEFITS *(Full-time employees only)*

_____ Extension of Benefits packet mailed on _____.
(Date)

2401 Lake Park Drive, S.E. • Smyrna, Georgia 30080-8862
404-920-7800 • Fax 404-920-7801 • archatl.com

THE ROMAN CATHOLIC
ARCHDIOCESE OF ATLANTA

Termination Notice

Employee Last Name:	**First Name:**	**Middle Initial:**
Street Address:		
City:	**State:**	**Zip Code:**
Telephone:	**SS#:**	

Name of Church or School (or Name of Chancery Office or Department):
Full-time: ☐ **Part-time:** ☐ **Temporary:** ☐
Position:
Ending Annual/Hourly Salary: $

Date of Termination:	**Is this a Reduction in Force?** ☐ **Yes** ☐ **No**
Vacation Days/Hours Taken and Not Earned:	**Vacation Days/Hours Earned and Not Taken:**
Date of Last Pay check:	**Please allow at least one pay cycle to process*
Date of Exit Interview:	**Date Extension of Benefits Mailed:**
Date Human Resources Notified:	
GA D. O. L. Separation Notice (Catholic Charities Only): ☐ **Yes** ☐ **No**	

TRANSFER OF EMPLOYMENT

Location Transferring To:	**Effective Date of Transfer:**
Comments:	

Business Manager Signature:	**Date:**

2401 Lake Park Drive, S.E. • Smyrna, Georgia 30080-8862
404-920-7800 • Fax 404-920-7801 • archatl.com

THE ROMAN CATHOLIC
ARCHDIOCESE OF ATLANTA

EXIT INTERVIEW

Name of Employee:	Employer Location:
Position:	Supervisor Name:
Date of Hire:	Date of Termination:

What made you decide to leave your current job? (Check all that apply)

Primary	Secondary	
		Secured Better Job
		Return to School
		Family
		Issues with Supervisor
		Problems with Hours
		Not satisfied with Wages
		Disliked type of work
		Professional level of job
		Quantity of Work
		Physical Condition
		Working Conditions
		Transportation Problems
		Other:

What did you like <u>most</u> about your job?

What did you like <u>least</u> about your job?

Do you feel training opportunities were made available to you? ☐ **yes** ☐ **no**

Comments:

Do you think your current supervisor was fair and reasonable? If not, please explain. ☐ **yes** ☐ **no**

Comments:

2401 Lake Park Drive, S.E. • Smyrna, Georgia 30080-8862
404-920-7800 • Fax 404-920-7801 • archatl.com

Do you believe you were given access to and realistic consideration for promotional opportunities? ☐ **yes** ☐ **no**

Comments:

Did you feel your contributions were appreciated by your supervisor and others? ☐ **yes** ☐ **no**

Comments:

Did you have the appropriate equipment and resources necessary to perform your job? ☐ **yes** ☐ **no**

Comments:

Was your salary satisfactory for the job you were performing? ☐ **yes** ☐ **no**

Comments:

Were you satisfied with the employee benefits provided? ☐ **yes** ☐ **no**

Comments:

Was the physical working environment comfortable and conducive to productivity? ☐ **yes** ☐ **no**

Comments:

Was the job realistically presented to you when you were hired, or did you most recently change position?
☐ **yes** ☐ **no**

Comments:

Do you have any suggestions for improvement?

Are there any changes which could have been made to prevent you from leaving?

Other comments, if any:

Interviewer **Date**

2401 Lake Park Drive, S.E. • Smyrna, Georgia 30080-8862
404-920-7800 • Fax 404-920-7801 • **archatl.com**

TERMINATIONS

The full time benefits termination packet includes the appropriate letter, an Extension of Benefits form, and the Hartford Notice of Continuation of Coverage form.

A copy of these must be returned to HR along with the Termination Notice. Samples of the three letters are included in this packet. If these letters do not apply, please contact Rosa Montano-Parker/Benefits Office for additional information.

You must complete and sign the Employer Section of the Hartford Notice of Continuation of Coverage.

Complete the Extension of Benefits form with the employee's name, the name of your location, and the date benefits eligibility ends.

NOTE: These letters do not apply to individuals who will receive severance due to Reduction in Force (RIF). Please contact the Human Resources Manager for proper procedures.

CHANGE OF STATUS

Part Time to Full Time:
When an employee's status changes from PT to FT, you can access the Full Time Benefits packet from the Human Resources webpage.
(https://archatl.com/offices/human-resources/)

This packet includes the benefit forms that must be completed by the individual.

Submit these forms along with the new Employee Personnel Record to HR.

Full Time to Part Time:
When an employee's status changes from Full Time to Part Time, you must provide the employee a Benefits Termination letter and appropriate forms. Please see section regarding terminations in this packet.

Submit these along with the new Employee Personnel Record to HR.

<DATE>

<EMPLOYEE NAME>
<ADDRESS>
<CITY, ST ZIP>

Re: Termination of Coverage & Continuation of Benefits

Dear <EMPLOYEE>;

Enclosed is a benefits termination packet, which includes forms for the following:

1. Extension of Benefits form (health insurance); and
2. The Hartford Notice of Continuation of Coverage

Due to your termination of employment (or change of status), your coverage under the group plans for health, life, and LTD, as well as any dependent coverage under the health or life plans terminates on <LAST DAY OF EMPLOYMENT>.

The Medical Extension of Benefits form must be completed and returned within 31 days to the Employee Benefits office with the first month's premium should you desire to continue your medical and dental benefits. Please see address for payments on the enclosed form. The premium increases every January and July.

There may be other coverage options for you (and your family). In the Health Insurance Marketplace (www.HealthCare.gov), you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for Extension of Benefits does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you may be eligible (i.e. spouse employer's), even if the plan generally does not accept late enrollees, if you request enrollment within 31 days.

If you choose to convert your Life Insurance and your Long Term Disability Insurance policies to individual policies, the forms must be submitted to Hartford Life Insurance Company within 31 days of the above termination date, or the date of this notice. Please keep a copy for your records.

Should you have any questions, please contact Rosa Montano-Parker at (404) 920-7486.

Sincerely,

<AUTHORIZING INDIVIDUAL>
<TITLE>

cc: Human Resources

<DATE>

<NAME>
<ADDRESS1>
<ADDRESS2>

Re: Termination of Coverage & Continuation of Benefits

Dear <NAME>:

Due to your termination of employment, your coverage under the group plans for medical, life, and LTD, as well as any dependent coverage under the medical or life plans will terminate at midnight on <LAST DAY EMPLOYMENT>.

Your participation in the diocese's health and life plans was less than 6 months. Therefore, you are not eligible to extend your health benefits, nor are you eligible to convert your Long Term Disability insurance.

There may be other healthcare coverage options for you (and your family). In the Health Insurance Marketplace (www.HealthCare.gov), you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Additionally, you may qualify for a special enrollment opportunity for another group health plan (e.g. a Parent's or Spouse's employer plan) for which you may be eligible, even if the plan generally does not accept late enrollees, if you request enrollment within 31 days.

If you choose to convert your Life Insurance to an individual policy, the attached form must be submitted to Hartford Life Insurance Company within 30 days of the above termination date, or your receiving this notice. Please keep a copy for your records.

Should you have any questions, please call Rosa Montano-Parker at (404) 920-7486.

Sincerely,

<AUTHORIZED INDIVIDUAL>
<TITLE>

Enclosed:
Hartford Life Insurance Conversion form

cc: Human Resources

<DATE>

<NAME>
<ADDRESS>
<CITY, STATE, ZIP>

Re: Termination of Coverage & Continuation of Benefits

Dear <NAME>;

Due to your termination of employment (or change of status), your coverage under the group plans for health, life and LTD, as well as any dependent coverage under these plans, terminates as of your termination date of <LAST DATE OF EMPLOYMENT>.

Due to normal retirement age guidelines you are not eligible to extend your health benefits, nor are you eligible to convert your Long Term Disability insurance.

If you choose to convert your Life Insurance policy to individual policy, the enclosed form must be submitted to Hartford Life Insurance Company within 31 days of your termination, or your receiving this notice. Please keep a copy for your records.

Attached please also find your Prescription Drug Creditable Coverage notice. You may need to present it to Medicare.

Should you have any questions, please call Rosa Montano-Parker at (404) 920-7486.

Sincerely,

<AUTHORIZED INDIVIDUAL>
<TITLE>

Enclosed:
Prescription Drug Creditable Coverage Notice
Hartford Life Insurance Conversion form

cc: Human Resources

THE ROMAN CATHOLIC
ARCHDIOCESE OF ATLANTA
OFFICE OF HUMAN RESOURCES

OTHER LETTERS THAT MAY APPLY

Extension of Benefits offer to a **Divorced Spouse**

Extension of Benefits offer to **Over Age Dependent Child**

Extension of Benefits offer to **Reduction in Force with Severance**

Please contact the Benefits Office regarding any of the above.

2401 Lake Park Drive, S.E. • Smyrna, Georgia 30080-8862
404-920-7480 • Fax 404-920-7481 • archatl.com

THE ROMAN CATHOLIC
ARCHDIOCESE OF ATLANTA
OFFICE OF HUMAN RESOURCES

Extension of Benefits

Group Health Care Plan

January 1, 2025 to June 30, 2025

Employee Name:	**SS#:**
Employment Location:	

I understand that my Group Health Care Plan **(Medical/Rx, and Dental/Vision)** benefits cease upon the date of loss of my benefits-eligible status with the Archdiocese of Atlanta. I also understand that there is a six (6) month maximum extension of Group Health Care Plan benefits available to me and that I must pay the full cost of the premiums.

☐ I elect **to decline** extension of my Group Health Care Plan benefits.
☐ I elect to pay the premiums and extend my Group Health Care Plan benefits as indicated below.

I will notify *Employee Benefits* if coverage is to be terminated earlier. **Coverage lapses automatically for late/non-payment.** I elect to extend for:

☐ one month ☐ two months ☐ three months ☐ four months ☐ five months ☐ six months

Cost per month

Value Plan		**Premier Plan**	
☐ Employee only	$1454.00	☐ Employee only	$1581.00
☐ Employee + Child(ren)	$1936.00	☐ Employee + Child(ren)	$2131.00
☐ Employee + Spouse	$2125.00	☐ Employee + Spouse	$2295.00
☐ Employee + Family	$2147.00	☐ Employee + Family	$2312.00

Please return completed form with your first payment.

When Extension of Group Health Care Plan benefits is elected, payment must be made by the **first of each month.**

All payments should be made out to The Archdiocese of Atlanta, and sent to the following address:

Archdiocese of Atlanta
ATT: Employee Benefits
2401 Lake Park Drive S.E.
Smyrna, GA 30080-8862

Phone: (404) 920-7486

Late/non-payment will result in cancellation of Group Health Care Plan benefits. Please keep a copy of this document for reference of payment mailing address.

Date of Loss of Benefits Eligibility:	
Signature of Employee:	**Date:**

THE ROMAN CATHOLIC
ARCHDIOCESE OF ATLANTA
OFFICE OF HUMAN RESOURCES

Extension of Benefits

Group Health Care Plan

July 1, 2025 to December 31, 2025

Employee Name:	SS#:
Employment Location:	

I understand that my Group Health Care Plan **(Medical/Rx, and Dental/Vision)** benefits cease upon the date of loss of my benefits-eligible status with the Archdiocese of Atlanta. I also understand that there is a six (6) month maximum extension of Group Health Care Plan benefits available to me and that I must pay the full cost of the premiums.

☐ I elect **to decline** extension of my Group Health Care Plan benefits.
☐ I elect to pay the premiums and extend my Group Health Care Plan benefits as indicated below.

I will notify *Employee Benefits* if coverage is to be terminated earlier. **Coverage lapses automatically for late/non-payment.** I elect to extend for:

☐ one month ☐ two months ☐ three months ☐ four months ☐ five months ☐ six months

Cost per month

Value Plan		Premier Plan	
☐ Employee only	$1490.00	☐ Employee only	$1617.00
☐ Employee + Child(ren)	$1972.00	☐ Employee + Child(ren)	$2167.00
☐ Employee + Spouse	$2161.00	☐ Employee + Spouse	$2331.00
☐ Employee + Family	$2183.00	☐ Employee + Family	$2348.00

Please return completed form with your first payment.

When Extension of Group Health Care Plan benefits is elected, payment must be made by the **first of each month.**

All payments should be made out to The Archdiocese of Atlanta, and sent to the following address:

Archdiocese of Atlanta
ATT: Employee Benefits
2401 Lake Park Drive S.E.
Smyrna, GA 30080-8862

Phone: (404) 920-7486

Late/non-payment will result in cancellation of Group Health Care Plan benefits. Please keep a copy of this document for reference of payment mailing address.

Date of Loss of Benefits Eligibility:	
Signature of Employee:	Date:

Business Manager must complete the

Employer Section

of the Hartford form, sign and dates.

A copy of the form should be sent to HR

along with the Termination Notice

And letterers provided to the employee

Notice of Conversion and/or Portability Rights

Important Notice regarding your coverage: You are receiving this notice as a result of experiencing a loss of coverage associated with The Hartford's Group policy provided by your employer. You have options to continue to be insured, which are explained below. The specific options available to you are based on the provisions as defined in the group policy. If you intend to apply for a policy, it is important that you submit a request for quote as soon as possible.

Life Conversion

The Life Conversion option provides the opportunity for you to obtain an individual life insurance policy that accumulates cash value and is offered at individual insurance rates. There are no mandatory age reductions and coverage can continue with premium payment until the Scheduled Maturity Date (standardly age 121) at which time the cash surrender value is paid to the insured. You will be eligible for Life Conversion if you experience a loss of coverage as the result of a change in your employment status, change in marital status, you or a dependent has experienced an age reduction or maximum age limit, you have retired or you have reached the end of an employer sponsored continuation provision. If coverage is ending because The Hartford Group Life policy is terminating or coverage for a class of employees is terminating, some restrictions may apply. If coverage is ending for any other reason, you can generally convert up to the full amount of your terminating coverage. Conversion is also available to your dependents if they had coverage under the group policy. You may have the option to obtain a one year term policy prior to the permanent life policy becoming effective. Please refer to The Hartford Group Life policy for information. **Premiums for a Life Conversion policy are substantially higher than the employer group policy rates.**

Life Portability

Under the Portability option you may obtain a group life insurance policy to continue 50%, 75% or 100% of the amount of life insurance coverage (Basic, Supplemental, or both) you had under the Group policy up to a maximum amount, generally $250,000 depending upon the provisions of the employer's group policy. The Portability policy provides group term coverage and is available to you provided you have not yet reached your Social Security full retirement age. The Portability option may also be available to your dependents if you carried dependent coverage under the employer's group policy and if the group policy includes portability as an option for dependents. The amount of coverage you elect to port is reduced by 75% at age 65 and coverage terminates at age 75. You will be eligible for Life Portability if you experience a loss of coverage as the result of a change in your employment status, change in marital status, you or a dependent has experienced an age reduction or maximum age limit, you have retired or you have reached the end of an employer sponsored continuation provision. **Note:** Portability is not available if your employer is terminating the group policy. If you choose to elect the Waiver of Premium provision as outlined in your Contract you are not eligible for Portability. The same applies if you choose to elect Portability, Waiver of Premium would not be available. Additional restrictions may also apply. **Premiums for a Life Portability policy may be higher than the employer group policy rates and rates increase every five years (years in which your age on your birthday ends in 5 or 0, for example 45 or 50.).**

Long Term Disability (LTD) Conversion

You may be eligible to convert coverage you had in effect under the employer's Group Long Term Disability (LTD) policy to a Group Disability Conversion policy provided the group coverage was in effect for at least one year. You cannot be disabled from performing the duties of your occupation at the time your LTD coverage terminates under the group policy or disabled at the time of your request and you cannot convert LTD coverage if you are retiring, regardless of your age. A loss of coverage is the result of a change in your employment status or the end of an employer sponsored continuation provision. **LTD conversion is not available for dependents.** The benefit amount payable under the LTD conversion will be based on your monthly earnings at the time the group policy ended and the benefit percentage elected up to 60% of your earnings at time of termination of employment under the employer's group policy, to a monthly maximum of $5,000. This amount is based on the rules of the LTD group policy subject to offsets for other income benefits. A 6-month elimination period applies. LTD conversion is not available if the group policy is terminating. **A onetime administrative enrollment fee of $25.00 will apply and is added to your first quarterly premium. Premiums for a Group Disability Conversion policy are higher than the employer group policy rates and increase every 5 years (years in which your age on your birthday ends in 5 or 0).**

08/2021

GROUP LIFE INSURANCE PORTABILITY AND CONVERSION – Side By Side Employee Guide

To decide whether Portability or Conversion is the right choice for your personal situation, you need to understand the differences. We help you see them clearly with our side-by-side comparison. Please visit www.hartford-employee-guide.com to view the complete side-by-side comparison table. If you do not have access to the internet you may obtain a copy of this comparison by calling 1-877-320-0484.

Frequently Asked Questions

Q: If I request a quote, how does The Hartford determine the amount of coverage to quote?
A: The quote is based on the amount of coverage you had under the group policy as well as any applicable policy provisions. The amount quoted is not a guarantee for your new coverage until The Hartford performs an eligibility review, validation of all information received, and medical underwriting, where applicable.

Q: What is my policy effective date?
A: When the application is approved and premium payment has been received, the effective date will be the day after your group benefits loss begins so that no gap in coverage would be experienced by you or your family.

Q: Can I be denied coverage?
A: Your request for coverage can be denied if you do not meet the timeline requirement as outlined above the signature line.

Q: If I start to work for a new employer and obtain coverage under that employer's group policy, will that group coverage impact any policy that I may purchase now?
A: If you obtain coverage under a new employer's group policy, your purchased policy(s) will remain in effect provided you continue to pay the required premiums.

Below is the information required to request a quote and the necessary forms to enroll. If you have questions about this information, your eligibility, or the status of any request you have submitted, please call a representative at **1-877-320-0484.**

The Hartford, Portability and Conversion Unit
P.O. Box 43786
Cleveland, OH 44143-0786
Fax 1-440-646-9339

E-mail request to: portabilityandconversions@selmanco.com **with "Notice of Continuation of Coverage" in the subject line**
https://info.selmanco.com/hartfordnocp

Employer Section: To be completed by the Employer or Employer Representative.

Employer: ROMAN CATHOLIC ARCHDIOCESE OF ATLANTA

Policy #: GL-044224 Employee ID#:

Employee Name:

Last Day Worked (or date employee is no longer in an eligible class):

Date of Group Coverage Loss: Loss of coverage reason:

Date of Hire: Base annual salary:

Life Coverage: Please provide coverage amount in place at the time of loss of coverage

- Employee Basic Life:
- Employee Supplemental Life:
- Spouse Supplemental Life: • Child Supplemental Life:

LTD Coverage: Please provide coverage amount in place at the time of loss of coverage

- Employee occupation
- Was the insured enrolled in the group LTD policy? If so as of what date? YES
- Monthly earnings insured under the LTD policy
- Benefit % provided by the LTD policy 60%

The Hartford reserves the right to request additional information prior to accepting an application.

Employer Signature **Print Name**

Employer Email Address rmontano-parker@archatl.com **Date**

Employee Section: To be completed by the Employee and submitted with the Employer Section via mail, fax, or e-mail, to initiate the quote and application for coverage options.

The Hartford, Portability and Conversion Unit, P.O. Box 43786, Cleveland, OH 44143-0786
Fax 440-646-9339, Phone 877-320-0484
E-mail request to: portabilityandconversions@selmanco.com with "Notice of Continuation of Coverage" in the subject line
https://info.selmanco.com/hartfordnocp

I am interested in receiving a Quote/Application for the following:

☐ 12 month Term/Whole Life Conversion (12 month only available for groups sitused in NY & WV)
☐ Portability Term Life
☐ LTD Conversion

Please print the following information:

Name: _____

Date of Birth: _____ Social Security # **(indicate last 4 digits only):** _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email: _____

I am interested in receiving information for the following persons:

☐ Myself ☐ My Spouse (not available for LTD conversion) ☐ My Child(ren) (not available for LTD conversion)

Please print the name(s), relationship, and date(s) of birth for each dependent who may be eligible for coverage. Include an additional sheet if necessary.

Name: _____ Relationship: _____ Date of Birth: _____

Name: _____ Relationship: _____ Date of Birth: _____

Name: _____ Relationship: _____ Date of Birth: _____

Name: _____ Relationship: _____ Date of Birth: _____

This notice is a part of a 3-step process to obtain coverage. For you to be eligible to start this process, your employer representative must have signed this notice no later than 90 days after the Group Coverage Loss Date. If your employer signs this notice prior to the Group Coverage Loss Date, we will treat the employer signature date as being the same as the Group Coverage Loss Date for purposes Steps 1 and 3.

Step 1: You have up to 31 days from the date your employer representative has signed this notice to submit this request (Employer AND Employee section) to The Hartford.
Step 2: Once we receive your completed request, we will send you an application and a quote. Depending on the mail, it may take two to three weeks for you to receive these. If you are concerned that you may not be able to obtain the application and quote in time to meet the deadlines outlined in Step 3, you may contact us by phone or email as outlined on this notice.
Step 3: If you choose to obtain coverage, you must submit the application and premium to us within 60 days from the date your employer representative has signed this notice.

_____ _____
Employee Signature (required) **Date**