

NOTICE OF SEPARATION FROM CITY SERVICE (NOS)

Name:		Employee ID:	
Department:	Job Classification:	Position Number:	
<input type="checkbox"/> Designated position: Form 700 must be filed with Clerk's Office upon separation			
MAILING ADDRESS FOR W-2 FORM AND COBRA PACKET			
Address:	City:	State:	Zip:
E-mail Address (for future communication purposes):			
TYPE OF SEPARATION (SELECT ONE)			
<input type="checkbox"/> Resigned	<input type="checkbox"/> Declined Employment	<input type="checkbox"/> Retired	<input type="checkbox"/> Deceased
<input type="checkbox"/> Laid off	<input type="checkbox"/> End of Temporary Employment	<input type="checkbox"/> Terminate Rehire Retiree	<input type="checkbox"/> Terminated (Involuntary)
<input type="checkbox"/> Other (see comments below)			
HIRE DATE (most recent):	REASON OR COMMENTS REGARDING SEPARATION (include attachments if necessary):		
LAST DAY ON CITY PAYROLL:			
CONTINUED GROUP HEALTH COVERAGE			
Benefits coverage will continue to the last day of the month of separation from City service. I understand that I am responsible for paying the employee share of premium expenses for that coverage through payroll deductions from my remaining paycheck(s), and that any outstanding balance will be billed to me.			
I hereby certify that I have been notified of my rights to purchase continued group health coverage after loss of coverage under the Consolidated Omnibus Budget Reconciliation Act (C.O.B.R.A.) of 1985. For further information, please refer to the Information for Separating Employees .			
EMPLOYEE'S SIGNATURE		DATE	
SUPERVISOR'S SIGNATURE		DATE	
HUMAN RESOURCES AUTHORIZATION		DATE	

Note to Supervisors/Department:

Please provide separating employee with either:
[Information for Separating Employees](#)(Benefited) or
[Information for Separating Employees](#)(Unbenefited)