TERMINATION OF BENEFITS / EMPLOYMENT NOTICE

DCSS 0114 (08/19/05)

TO: Employer Name
Employer Address
Employer City, State, and Zip Code

DATE:
PHONE:
EMPLOYEE:

FROM: COUNTY OF SAN DIEGO DEPARTMENT OF CHILD SUPPORT SERVICES
PO BOX 122031
SAN DIEGO CA 92112-2031

SSN:
DOB:

Participant Number:

TERMINATION OF BENEFITS / EMPLOYMENT NOTICE

INSTRUCTIONS: Use this form to report termination of employment or benefits of an employee for whom you have a requirement to withhold support and/or provide health benefits.

Termination of: ☐ Employment ☐ Health Benefits ☐ Both

DATE OF TERMINATION - BENEFITS	REASON FOR TERMINATION	
COBRA HEALTH INSURANCE AVAILABLE? ☐ NO ☐ YES, coverage thru:_____ DATE		
DATE OF TERMINATION - EMPLOYMENT	REASON FOR TERMINATION	SUBJECT TO REHIRE? ☐ NO ☐ YES
LAST KNOWN HOME ADDRESS (Street address, City, State, Zip code)		TELEPHONE NUMBER
NEW EMPLOYER'S NAME (if known)		TELEPHONE NUMBER
NEW EMPLOYER'S ADDRESS (if known - Street address, City, State, Zip code)		

CERTIFICATION OF RECORD

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

SIGNATURE DATE

PRINTED NAME

TITLE

Clear Form

Submit