Michigan Conference of Teamsters Welfare Fund

Serving Teamster families since 1949

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NOTIFICATION OF CHANGE IN PARTICIPANT EMPLOYMENT STATUS

Employee's Name: _____ Social Security Number: _____-_____-_____

Complete the appropriate section as it pertains to the Participant's employment status notification and fill out the Employer information below.

Section 1 – CHANGE TO A NON-ACTIVE STATUS

Last Date Worked: _____ (MM/DD/YY) Date of Status Change: _____ (MM/DD/YY)

Contributions must be remitted pursuant to any contribution obligation provided for in the Participation Agreement and/or Collective Bargaining Agreement. Failure to timely notify MCTWF of employment status changes will obligate the Employer for contributions on behalf of the Participant through the date the status change is ultimately reported. **Please identify the participant's non-active status by checking the appropriate box below:**

- ☐ Deceased / Date_____
- ☐ Disabled – On-the-Job*****
  FMLA Yes / No (circle one)
- ☐ Disabled – Off-the-Job
  FMLA Yes / No (circle one)
- ☐ Fired
  - ☐ Due to Gross Misconduct
  - ☐ Due to Other than Gross Misconduct
- ☐ Laid Off
- ☐ On Military Leave
- ☐ On Strike
- ☐ Locked Out
- ☐ On Personal Leave
  FMLA Yes / No (circle one)
- ☐ Quit
- ☐ Reduced Hours (Explain below)
- ☐ Retired
- ☐ Suspended
- ☐ Other (Explain below)

Explanation: _____

*****If status change is due to an on-the-job illness or injury, please provide a copy of the Employer's Report of Injury. The Submission of the report of injury must not delay the submission of the employment status change.

Section 2 – RESUMPTION OF ACTIVE STATUS

Participant has resumed active employment as of: _____ (MM/DD/YY)

Section 3 – NEW EMPLOYEE INFORMATION

Hire Date: _____ (MM/DD/YY) ******Required Contribution Commencement Date: _____ (MM/DD/YY)

Participant Date of Birth: _____ (MM/DD/YY)

Participant Address: _____ (street address, city, state, zip)

**MCTWF requires that contributions be made on behalf of an Employee commencing no later than for the week in which falls the 91st day following the commencement of the individual's employment as an Employee.

In order for coverage to commence, MCTWF must receive a fully completed Enrollment Card and all required supporting documentation.

Employer Name: _____ Company #: _____

Employer Representative Name: _____ Title: _____

Employer Representative Signature: _____ Date: _____ (MM/DD/YY)

Send this completed form to employmentstatuschange@mctwf.org or fax to 313-964-3144 (no cover sheet required). For inquiries, contact your Employer Account Representative at 313-964-2400.

08/20