Civil Service Superannuation Board

Public Service Group Insurance Fund
Termination Notice for Insurance Only Members

To be completed in full by Department and forwarded to the CSSB as soon as final premium deductions are made.

PLEASE PRINT OR TYPE

a) Name of Employee: _____
(Last Name) (Given Names in Full)

b) Social Insurance Number: _____

c) Date of Birth: _____
YYYY MM DD

d) Home Address: _____

e) Home Phone Number: _____

f) Employee Number: _____

g) Date Entered Insurance Plan: _____
YYYY MM DD

h) Date of Termination: _____
YYYY MM DD

i) Last Physical Day Worked: _____
YYYY MM DD

j) Termination Due To Ill Health: _____/_____
Yes No
(n/a if employee age 65 or over)

k) Insurance Annual Salary at Date of Termination: $_____

l) Insurance Class At Termination: _____

m) Insurance Coverage At Date of Termination (Before Age Reduction): (k x l) $_____

n) Dependents Units _____

o) Spouse's Date of Birth _____
YYYY MM DD

p) The Department has deducted a final premium of $ _____ and $ _____ from the _____
Life Insurance Dependents Ins. Bi-Weekly/Monthly

salary of $ _____ on the payroll of _____ to _____ to provide insurance to
YYYY MM DD YYYY MM DD

_____.
YYYY MM DD

_____ _____ _____
Authorized Signing Officer Print Name of Authorized Signing Officer Date

_____ _____ _____
Employer Department Phone Number

Mail to: The Civil Service Superannuation Board
1200-444 St. Mary Ave
Winnipeg MB R3C 3T1