



Leave of Absence & Layoff Provision Notice

The Leave of Absence & Layoff Provision Notice (the Notice) is required when an employee is not meeting minimum eligibility requirements as defined in the Joinder Agreement and the Coverage Layoff Provision (the Provision) has been elected by the employer.

Under the Provision:

- The employee has elected to continue group health coverage for a period of up to three (3) calendar months, beginning the first of the month following the date active status ceased or work hours were reduced.
 - During this time, the employer is not required to make their usual contribution towards the employee's medical premium.
 - Payment arrangements must be made between the employer and employee, and such payment must be submitted to the TPM Trust by the employer.
- It is the responsibility of the employer to monitor the three (3) month period and to notify the TPM Trust when the employee meets the minimum eligibility requirements.
- If the employee does not regain eligible status within the three (3) month period COBRA Qualifying Event or Notice to Terminate Benefits form must be submitted by the employer.
 - Failure to notify the TPM Trust shall result in Employer liability for any claims paid on behalf of the named employee after the expiration of the three (3) month period.

The employer will complete the Notice and send to the TPM Trust. The employer will retain a copy of the Notice until:

1. The employee returns to work, and/or
2. Achieves enough hours to meet the minimum eligibility requirement, or
3. Employment is terminated.

Once one the above has occurred, the employer will complete the bottom of the Notice and submit the updated Notice to the TPM Trust.



Timber Products Manufacturers Trust
951 East Third Avenue, Spokane, WA 99202

Leave of Absence & Layoff Provision Notice

**This Notice does not replace the COBRA Qualifying Event or
Notice to Terminate Benefits forms**

Group Name: _____ Group Number: _____

Employee Name: _____
Last, First

Employee SSN: _____

The above named employee's work status has changed due to one of the following reason:

- | | | |
|--------------------------|-----------------------|--------------------------|
| 1.) Work Related Injury | 2.) FMLA | 3.) State-Approved Leave |
| 4.) Other Approved Leave | 5.) Temporary Lay-Off | 6.) Reduced Work Hours |

Date Status Changed: _____

If returning to work:

Date employee met the minimum eligibility requirements: _____

- Employee will be eligible the first of the month following this date.

If not returning to work:

Date employee's coverage terminated: _____

- Submit a COBRA Qualifying Event or Notice to Terminate Benefits Form as applicable with this notice.

Notice To Be Sent To:
TIMBER PRODUCTS MANUFACTURERS TRUST
enrollments@tpmrs.com

**951 E THIRD AVE
SPOKANE WA 99202
PHONE: (877) 535-4646 / FAX: (509) 533-1947**