

## THE DIOCESE OF CALIFORNIA'S PAYROLL & BENEFITS SERVICE TERMINATION PROCESS & PAPERWORK

Employees who are terminated or laid off are due their final paycheck with all hours worked and any accrued but unused vacation or PTO time on their last day **worked**. In addition, all voluntary resignations with 72 or more hours' notice, are due their final pay including vacation or PTO on their final day worked. Employees giving less than 72 hours' notice, must receive their final check within 72 hours of their *notice*. Employers cannot request employees wait until the next regular payday under any circumstances.

Terminated employees must be paid at the place of termination. If you mail the final check, the employee must have it in their hands at the moment you tell the employee that they no longer have a job. In addition, direct deposit also terminates when an employee does. Therefore, unless you have the written consent from the employee, final checks must be in live form even if they had previously authorized direct deposit of their paycheck.

Waiting time penalties apply for not providing the final check on the last day worked. This means that for each *calendar* day the check is late, you must pay a full day's wages to the employee until they receive the final paycheck to a maximum of 30 calendar days.

This packet contains instructions and forms for employer to complete and return to Diocese, to complete and keep in your local personnel files, as well as informational forms that are to be provided to the terminating employee. Please read through all pages and call Diocese with any questions.

### **Form to be completed in the termination process.**

1. **Termination Notice:** Completed by employer and returned to the Payroll & Benefits Office prior to final pay date, if possible.
2. **Final Paycheck Acknowledgement.** It is best practice to have an employee confirm receipt in writing of their final paycheck to prove that you paid all wages timely. Keep original in your local, on-site, personnel files. A copy may be sent to Diocese.
3. **Change in Relationship (required in State of CA)** This should to be completed for all exiting employees and employees going on a leave of absence. Keep original in your local, on-site, personnel files. A copy may be sent to Diocese.

**Forms for employer to print and provide to departing employee.** Make sure to note the date these were provided to employee on Termination Notice to Diocese:

1. **HIPP Notice (required in State of CA)** – This must be given to all exiting employees who were on your group health insurance plan. If the employee was not on your health insurance plan, this is not required.
2. **Programs for the Unemployed (required in CA)** –this pamphlet (which can be ordered at no cost from the [EDD](#)) must be given to all exiting employees, even if they are not eligible to collect unemployment. See below for Salary Continuation, DioCal benefit provided to all employees working at least 20hr/week in lieu of SUI.
3. **Extension of Benefits Information Page:** Religious non-profit employers **do not have COBRA** obligation under federal laws and regulations. However, The Episcopal Church Medical Trust provides an Extension of Benefits (EoB) for medical and/or dental. Page 3 of this packet outlines the basic provisions of this policy.
4. **Salary Continuation Information & Claim Form:** As a religious non-profit employer we are exempt from, and do not participate in, State of California Unemployment Insurance program. Salary Continuation benefits are provided to employees working at least 20hr/week in lieu of SUI.
  - a. **Employee** has 30 days from termination date to apply for benefits by filing the claim form directly to Health Equity Wage Works, the plan administrator.
  - b. The Salary Continuation plan administrator will contact the employer to verify application details, please respond in a timely manner.
  - c. If the former employee was paid through the Diocese of California's payroll service and their claim is approved the Diocese payroll office we will handle the payment of benefits. Otherwise we will contact you to arrange for you to issue payments to former employee and coordinate reimbursement from DioCal.

## TERMINATION NOTICE TO DIOCESE OF CALIFORNIA

Employing Entity, City: \_\_\_\_\_ Parish Code: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Last Day Worked: \_\_\_\_\_

**Employee's current contact information** (required for EOB offer & year end payroll documents):

Street/City/State/Zip: \_\_\_\_\_

Preferred Phone & Personal Email: \_\_\_\_\_

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**Remove Employee from Benefits** (employees working 20+ hrs./wk have benefits)

Employment ending because of (circle one): **Termination, Resignation, Retirement, Death**

Employee benefits end date (mm/dd/yy): \_\_\_\_\_ Employee receives health and dental coverage through the last day of the month indicated. For example, Jan 1 or Jan 16 = Jan 31<sup>st</sup> cancellation of coverage.

See attached information on deadlines to file for Extension of Benefits or Salary Continuation

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**Remove Employee from Diocesan Payroll**

**1) To issue final paycheck on day of termination:** contact the DioCal payroll office to report the total gross pay owed which includes the cash value of accrued vacation or PTO benefit. Diocese will provide you with the Gross to Net details (including taxes and other appropriate deductions) so the employer can write the final check for employee. Employer must return a copy of the final check issued with a copy of the Final Check Acknowledgment and this notice to the Diocesan Payroll Office by fax: 415-673-4863 or email: sarahc@diocal.org

**OR** if final day of work falls on pay date and employee requests (in writing) to receive their final check with the regular payroll cycle

**2) Process final paycheck with regular payroll on this date:** \_\_\_\_\_ 15<sup>th</sup> or \_\_\_\_\_ 30<sup>th</sup>/31<sup>st</sup>

Use the timesheet to indicate any amount of pay to be added (+) or deducted (-) from the final paycheck (i.e.: salary adjustment, accrued vacation)

**OR**

**3) If the final paycheck has already been issued through DioCal Payroll Service specify the date of last check issued:**

\_\_\_\_\_ 15<sup>th</sup> or \_\_\_\_\_ 30<sup>th</sup>/31<sup>st</sup>

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**Employer verifies that** HIPP Notice, Program for the Unemployed, Extension of Benefits & Salary Continuation information was provided to the terminating employee on the date of: \_\_\_\_\_

Prepared by: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Contact Email: \_\_\_\_\_

Termination Notice should be returned by fax to 415-673-4863 or email to sarahc@diocal.org

## **Extension of Benefits Information (Medical and Dental)**

Religious non-profit employers **do not have COBRA** obligation under federal laws and regulations. However, The Episcopal Church Medical Trust does provide an Extension of Benefit option for our employees and their eligible dependents. The following outlines the basic provisions of this policy.

1. Extension of Benefits will be offered by The Episcopal Church Medical Trust. ECMT will send information & instructions directly to you. If you have questions on extension of benefits, please call ECMT client services, M-F 5.30am-5pm PT:

**1-800-480-9967**

2. Extension of Benefits may be continued for a maximum of 36 months. Coverage must be in place at the time of the termination of your employment. Only those dependents covered at the time of termination may be remain on the plan if primary member continues coverage.
3. **The terminated employee pays the cost of the coverage** effective the first of the month following date of termination. For example: if your employment ends on April 12 your employer will continue your coverage until April 30, then former employee will assume responsibility for coverage effective May 1.
4. Canonically resident clergy have the option to continue benefits through the Diocese with no term limits. Cleric should contact DioCal Benefits Office to request information and form to continue medical and/or dental coverage directly with Diocese.

## **Salary Continuation Benefits Program (in lieu of State Unemployment Insurance for lay & clergy)**

**PURPOSE:**

To provide full-time (20 hours or more a week) lay and clergy employees a Salary Continuation Benefits Program intended to benefit those individuals whose employment within the Diocese of California is discontinued for reasons beyond their control.

**ELIGIBILITY:**

**Salary Continuation Benefits are payable to lay and clergy employees working 20 hours or more a week, and continuously employed for a minimum of 90 days, who qualify for benefits for the reasons described below.**

**BENEFITS:**

The amount of Salary Continuation Benefits for eligible employees will be determined by length of service and average weekly salary. Eligible employees will earn one week of Salary Continuation Benefits for every calendar month employed (starting with their date of employment to a maximum of 26 weeks. Eligible employees will be entitled to a weekly benefit amount equal to 40% of their average weekly salary for the actual period of employment up to 26 weeks immediately preceding separation of employment, to a maximum weekly benefit of \$555.00.

**CLAIMS ADMINISTRATION:**

Determination of claimant's eligibility and approval of payment of benefits are the responsibility of a third-party Claims Administrator, appointed by the Personnel Practices Committee which serves as Trustee for the Salary Continuation Benefits Program. The Claims Administrator is responsible for determining eligibility for benefits at the time a claim is first presented by the employee. Eligibility for benefits will cease when claimant gains employment.

Eligibility for continuing weekly benefits is determined by a bi-weekly audit conducted by the Claims Administrator.

Either the employee or employer may appeal eligibility determinations within 15 days of such determination being communicated in writing to both parties. Such appeals will be referred to an impartial Arbitrator experienced in unemployment benefits practices and procedures who will hear testimony by both parties in order to reach a final decision.

A details explanation of Claims Procedures follows.

**I. QUALIFICATION – Eligible employees may qualify for weekly Salary Continuation Benefits if they**

**A) Quit for a job related cause because of:**

- 1) Threat of safety in the workplace
- 2) Reduction in working hours of 20% or more
- 3) Work-related stress if substantiated by medical documentation
- 4) Proven discrimination in the workplace based on that individual's race, color, sex, national origin, ancestry, or physical handicap
- 5) Proven sexual harassment provided the individual has taken reasonable steps to preserve the working relationship
- 6) Required resignation because of change of clergy leadership
- 7) Completion of non-renewable fixed-term contract

**B) Were improperly discharged, provided:**

- 1) Discharge is without sufficient documented warning (at least one verbal and one written warning, except for act of gross misconduct)
- 2) Discharge is solely based on employee's unavoidable absence or tardiness. Unavoidable absence or tardiness includes: a) death in the immediate family, b) unlawful detainment, c) hospitalization for treatment of an emergency or life-threatening condition, d) due to a summons to serve jury duty or a court subpoena
- 3) The employee is not offered similar or same position at similar or same rate of pay upon returning from authorized leave of absence

- C) Were discharged for lack of work resulting from
  - 1) Reduction in force
  - 2) Elimination of position

- II. DISQUALIFICATION – Claimant will be denied weekly Salary Continuation Benefits should one or more of the following conditions occur:
  - A) Discharge for gross misconduct, such as deliberate disregard for the well being of the employer and/or employees.
  - B) Job abandonment defined as unreported absence of three (3) or more days
  - C) Failure to Comply with employer’s wishes that employee seek professional treatment for substance abuse
  - D) Employee willfully made a false statement or representation, with actual knowledge of the falsity, or withheld a material fact in completing employment application or in filing a claim for Salary Continuation Benefits
  - E) Voluntarily quit without work-related cause
  - F) Voluntary retirement
  - G) Failure to comply with the rules and policies of the employer as established by the employer’s personnel policy.
  - H) Temporary lack of work due to established vacation, holiday or recess periods, provided reasonable assurance of re-employment is given prior to said period
  - I) Individual becomes unable to work due to a physical or mental illness or injury unrelated to his/her job

III. FILING A CLAIM

- A) Separated employee may file a claim for Salary Continuation Benefits by completing a Salary Continuation Benefits Claim form within 30 days of the official date of separation from the Diocese
  - 1. Completed forms must be submitted to the Claims Administrator at the following address and post-marked within 30 days of separation.
  - 2. The Claims Administrator will render a benefits decision within 10 working days of receipt of the claim form and employer verification.

IV. FILING AN APPEAL

- A) Disputed benefits decisions may be appealed by either party within 15 days of the date indicated on the notice of decision.
  - 1. Such appeals must be submitted in writing by the appellant to the Claims Administrator:

Health EquityWageWorks – ATTN: Nancy Comdohr  
735 N Water St., Ste 1500  
Milwaukee WI 53202  
Email: Nancy Comdohr, [NComdohr@healthequity.com](mailto:NComdohr@healthequity.com)
  - 2. Upon receipt of the appeal a Notice of Hearing will be issued to the claimant and the employer by an Arbitrator
    - a) Attendance at the hearing at the time and date indicated on the Notice of Hearing is mandatory
  - 3. The decision of the Arbitrator is final

**Salary Continuation  
BENEFITS CLAIM FORM  
(in lieu of State of CA unemployment)**

Claimant's Name: \_\_\_\_\_ Last 4 SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Job Title / Description: \_\_\_\_\_

Dates of Employment First day: \_\_\_\_\_ to Last day: \_\_\_\_\_

Employing Entity Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name & Title of Immediate Supervisor: \_\_\_\_\_  
(Supervisor will be contacted to verify Salary Continuation claim form)

Supervisor's Contact Information:

Phone #: ( ) \_\_\_\_\_

Fax #: ( ) \_\_\_\_\_

Email: \_\_\_\_\_

Are you able to work, available for work and actively seeking work?

(circle one) **YES** **NO**

Did you voluntarily quit your job?

(circle one) **YES** **NO**

Were you discharged or fired for reasons other than lack of work?

(circle one) **YES\*** **NO**

if yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return completed claim form to:**  
Health Equity Wage Works – ATTN: Nancy Comdohr  
735 N Water St., Ste 1500  
Milwaukee WI 53202  
Email: Nancy Comdohr, [NComdohr@healthequity.com](mailto:NComdohr@healthequity.com)