TERMINATION OF EMPLOYMENT

This form is used to report district employment terminations (e.g. resigned, terminated, RIF, hourly reduction (ineligible), termination of employees having waived medical coverage, or death).

Do not use form to drop dependents or to change status from active to retired (use MUST Change Form).

***Date of Termination:** The exact date the employee left employment (i.e., last date employee worked as an eligible employee or the last day the employee is eligible for coverage per the terms of the employment contract). All coverage terminations are effective at the end of the month.

****Termination Reason:** For example: resigned, terminated (please indicate whether termination is voluntary or involuntary), RIF, hourly reduction (ineligible), death, or termination of employees having waived medical coverage. *In case of gross misconduct, the employee is ineligible for COBRA. MUST does not determine gross misconduct.*

Please fax completed form(s) to Montana Unified School Trust: (406) 442-4161 or email to contact@ms-sf.org

School District Name:	Group No:

Employee Full Name and Last Known Address	LAST 4 OF SSN #	Date of Termination*	Termination Reason**
Full Name: Address: City: State: ZIP:			Voluntary Involuntary Gross Misconduct RIF Hourly Reduction Death Resigned
Full Name: Address: City: State: ZIP:			Voluntary Involuntary Gross Misconduct RIF Hourly Reduction Death Resigned
Full Name: Address: City: State: ZIP:			Voluntary Involuntary Gross Misconduct RIF Hourly Reduction Death Resigned
Full Name: Address: City: State: ZIP:			Voluntary Involuntary Gross Misconduct RIF Hourly Reduction Death Resigned
Full Name: Address: City: State: ZIP:			Voluntary Involuntary Gross Misconduct RIF Hourly Reduction Death Resigned
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Full Name: Address: City: State: ZIP:			Voluntary Involuntary Gross Misconduct RIF Hourly Reduction Death Resigned

Termination of Employment form revised 3/2021

FOR MUST USE ONLY: Date Entered ____/____/____

NOTES: ____________________Q/A INIT___________