RESET FORM

OPTIMAL MEDICAL BENEFIT ADMINISTRATIVE SERVICES

Notice Of Departures

3075 Fourteenth Avenue, Suite 221, Unionville, ON L3R 0G9 T 905-946-8444 F 905-946-8944 info@ombas.ca www.ombas.ca

A Private Health Services Plan as defined in S.248(1) of the Income Tax Act

Employer

Date yyyy mm dd Phone ( )

Contact Name

Employee Name	Employee Classification	Annual Medical Expenditure Limit		Final Date of Employment
		Single	Family	

I/We confirm the above individual/s are no longer employed at (company) on a full time basis. The listed employee(s) is aware that they are no longer entitled to OMBAS benefits as of their final day of employment. Should any of the above individuals have medical claims that pre-date their termination which have not been sent to OMBAS yet, those claims will be submitted to (company) directly and then sent to OMBAS for processing.

(Employer) _____

(Employer) _____

_____

I have the authority to bind the Employer