

## Termination Request: Equivalent Plan Substitution

This form is used to terminate a Minnesota Paid Leave Equivalent Plan Substitution that has been approved and is in effect. Once this form has been completed, please submit it by email to [EmployerServices.DEED@state.mn.us](mailto:EmployerServices.DEED@state.mn.us).

Is your plan currently active:

Yes

No

**Note:** If your equivalent plan is not yet active, you should submit a Withdrawal Request Form.

### Company Information

Business name: \_\_\_\_\_

FEIN: \_\_\_\_\_ EAN (optional): \_\_\_\_\_

### When do you want the termination to take effect?

Please select one of the following dates:

March 31

September 30

June 30

December 31

**Note:** Under Minnesota Rules, part 3317.5000, subpart 2, voluntary terminations must occur at the end of a calendar quarter. Only the dates listed above are allowable termination dates.

### How will you provide paid leave coverage after this termination?

State plan

Equivalent plan

*If you will use a new equivalent plan, please provide the plan details:*

Insurance carrier: \_\_\_\_\_

Policy number: \_\_\_\_\_

Effective date: \_\_\_\_\_

**Note:** If you will use an equivalent plan, you must have a new plan approved by the state before you submit this Termination Request Form. Your new plan must start immediately after your current plan ends, so that employees have continuous Paid Leave coverage. If there is a gap in coverage, you will be fined. For more information on Equivalent Plan Substitution Requests, including deadlines, visit the Paid Leave [equivalent plans webpage](#).

## Acknowledgment

By submitting this termination request, I acknowledge that:

- As required by Minnesota Statutes, section 268B.10, I must:
  - Notify Paid Leave of my intent to terminate the plan **at least 30 days in advance** of the effective date of the termination
  - Notify my employees of the change **at least 30 days in advance** by hanging a workplace poster *and* informing employees individually in writing
  - Provide a **secondary notification to employees within 7 days of the effective date of the termination**, indicating employees are covered by the state plan or a new equivalent plan because of the termination
  - Continue any leave approved under the equivalent plan, including payment, for the **full duration of the leave**
  - Remain in the state plan for at least 3 years following the termination, unless I am switching to a new equivalent plan that takes effect immediately following the termination of my current plan
- If my plan is canceled with my insurer **prior to the effective date of termination** and Paid Leave obligations are not met, I will be charged a fine **per employee per day of non-compliance** in accordance with Minnesota Statutes, section 268B.10, subdivision 20 (c).

## Confirmation

By signing below, I affirm that I am requesting a voluntary termination of the Equivalent Plan Substitution for the company named above.

I verify that I am a Paid Leave Administrator for the company named above.

I confirm that I have the authority to proceed with this termination.

Name: \_\_\_\_\_

Job Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_