**Termination / Change Form**

Employer Group #

[ ]  **Termination of Employment** [ ]  **Drop Coverage for** [ ]  **(Employee /** [ ]  **Dependent(s)**

 [ ]  **Name Change** [ ]  **Address Change**

|  |  |
| --- | --- |
| **EMPLOYEE INFORMATION (Please print)** |  |
| Employee Name |
| Social Security # | Date of Birth | Location/Division (if applicable) |
| Home Address | City | State | Zip Code |
| **REASON FOR LOSS OF COVERAGE** |
| Date of event: [ ]  Temporary [ ]  Permanent[ ]  Termination of employment (Retirement, Layoff or Dismissal) [ ]  Disability[ ]  Reduction in hours causing loss of eligibility [ ]  Death of covered employee[ ]  Military Leave (31 days or longer) [ ]  Dependent ceasing to be eligible under the Plan[ ]  Medicare entitlement resulting in loss of coverage [ ]  A child is born or adopted[ ]  Divorce or legal separation (ex-spouse mailing address) [ ]  Married [ ]  A dependent child reaches the coverage limit of the plan[ ]  Divorced [ ]  Change in full-time or part-time employment for employee[ ]  Spouse commenced or terminated employment [ ]  Change in full-time or part-time employment for spouse[ ]  Death of a dependent [ ]  Return to work following leave of absence for employee[ ]  Unpaid leave of absence by employee [ ]  Return to work following leave of absence for spouse[ ]  Unpaid leave of absence by spouse Explanation of Other Changes:  |
| **FAMILY MEDICAL LEAVE OF ABSENCE (FMLA)** |  |
| Employee not returning to work following Family Medical Leave of AbsenceLast day worked Premiums have been paid in full during leave? Yes NoNotes  |
| **COVERAGE UPON TERMINATION** |
|  **Medical** [ ]  Employee [ ]  Employee + Spouse [ ]  Employee + Child(ren) [ ]  Family  |
| **DEPENDENTS BEING DROPPED/TERMINATED** |
| Name: Last, First, MI | Date of Birth | Relationship | Gender(M / F) | Social Security Number***Required for Federal Funding*** |
| M | D | Y |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Do all dependents reside at the same address as the employee? [ ]  Yes [ ]  No  |
| If NO, list dependent’s name and address |  |
|  |
| If last name is different for dependent(s), please explain |  |
| **SIGNATURE:** | **DATE** |  |
|  |  |
| **EBSO USE ONLY** |
| Rims: | Rx: | Notice: | Other: |