**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 Absence  Last day worked Premiums have been paid in full during leave? Yes No  Notes | | | | | | | | | | | | | | | | | |
| **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 | |
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| 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: | | | | | |