Allied

Please Complete and return via FAX or E-mail

Call/Fax:
Tel: 888-292-0272
FAX: 312-416-2860
E-mail:
NGBS.MemberTermination@alliedbenefit.com

FORM INSTRUCTIONS

Please complete the form and submit to Allied within 30 days of a member coverage termination.

EMPLOYER INFORMATION

Group Name:	
Group Number:	

EMPLOYEE INFORMATION

Employee Name: _____ (Last) _____ (First) _____ (Middle Initial)

Employee Social Security Number: _____	**Employee Date of Birth:**	**MM** _____	**DD** _____ **CCYY** _____

Employee Address	**City**	**State**	**Zip Code**

TERMINATION INFORMATION

Date of Insurance Term:	☐ **End of Month** ☐ **14th of Month** (*Only applies if your Group Effective date is the 15th of the Month)*	**Date of Qualifying Event/Termination:**	**MM** _____	**DD** _____	**CCYY** _____

Qualifying Event Reason (choose one)

☐Employee's Termination or Employee's Layoff	☐Employee's Reduction in Hours	☐Employee's Death	☐Spouse's Divorce or Legal Separation from Employee
☐Dependent Child Ceasing to Qualify Under the Plan	☐Medicare Entitlement	☐Dropping Coverage (specify on form which member is to be termed)	☐Terminate back to effective date (no coverage-terminated prior to effective date with Allied)

If a Termination of Employment was the Qualifying Event, please indicate whether the Termination was Voluntary or Involuntary:

☐Involuntary ☐Voluntary

TERMINATION OF MEDICAL COVERAGE REQUEST

Employee Name	**Relationship**	**Gender**	**Birth Date MM/DD/CCYY**	**Social Security Number**	**Effective Date MM/DD/CCYY**	**Coverage Type**
	Employee	☐M ☐F				☐Med
Dependent Name(s)						
	☐Spouse ☐Child	☐M ☐F				☐Med
	☐Child	☐M ☐F				☐Med
	☐Child	☐M ☐F				☐Med
	☐Child	☐M ☐F				☐Med

AUTHORIZATION

I certify that the above information is accurate. *If applicable*, I authorize Allied Benefit Systems, Inc. to notify those individuals whom I have certified of their COBRA rights and creditable coverage.

_____ Signature of Authorized Company Representative

_____ Date

For Office Use Only:	Date Processed: / /20	By:_____