Simplified Funding Concepts Eligibility Change/Termination Form

Submit completed form to sfc.eligibility@ebso.biz

Note: The full enrollment form should be used to add new members.

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)
☐ Reduction in hours causing loss of eligibility
☐ Military Leave (31 days or longer)
☐ Divorce or legal separation (ex-spouse mailing address)
☐ Disability
☐ Medicare entitlement resulting in loss of coverage
☐ Spouse commenced or terminated employment
☐ Unpaid leave of absence by employee
☐ Unpaid leave of absence by spouse
☐ Death of covered member
☐ Dependent ceasing to be eligible under the Plan
_____
☐ A dependent child reaches the coverage limit of the plan
☐ Change in full-time or part-time employment for employee
☐ Change in full-time or part-time employment for spouse
☐ Return to work following leave of absence for employee
☐ Return to work following leave of absence for spouse
☐ Other:_____

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 M	D	Y	Relationship	Gender (M / F)	Social Security Number ***Required for Federal Funding***

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:	**TITLE**	**DATE**

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Revised 11/24/14