



DECLARATION OF TERMINATION OF ELIGIBILITY FOR DEPENDENT CHILD(REN)

I, _____, certify and declare that the
(Print Employee Name)

Dependent Child(ren) listed below are no longer eligible for coverage under the Costco Employee Benefits Program.

Dependent Names: _____

These Dependent Child(ren) are no longer eligible due to:

- No longer a full-time student
- No longer my eligible tax dependent
- Marriage
- No longer resides with me
- Death
- Other _____

The effective date of the event marked above is _____
(Date)

I understand that coverage will terminate on this date.

I understand that a COBRA Election Form and HIPAA Certificate will be mailed to me at my home address. I agree to forward these documents to the Dependent Child(ren) listed above.

I affirm, under penalty of perjury, that the above statements are true and correct.

Print Employee Name

Employee #

Employee Signature

Date