

# Member Termination Form

To be completed by the Benefits Administrator.

Group Information		
COMPANY/GROUP NAME	GROUP #	
GROUP CONTACT PERSON	TITLE	
CONTACT EMAIL	CONTACT PHONE #	DATE
SIGNATURE OF AUTHORIZED GROUP CONTACT		

Member Information		
MEMBER NAME (FIRST NAME, LAST NAME)		
SOCIAL SECURITY #	LAST DATE OF EMPLOYMENT OR LAST DAY OF COVERAGE (if applicable)	
MAILING ADDRESS (Required)		
CITY	STATE	ZIP CODE

Reason for Termination	
<b>Plan coverage to terminate:</b> <input type="checkbox"/> Dental <input type="checkbox"/> Vision  <input type="checkbox"/> Voluntary termination of employment <input type="checkbox"/> Obtained other coverage or covered through spouse <input type="checkbox"/> Voluntary termination of coverage <input type="checkbox"/> Involuntary termination of employment <input type="checkbox"/> Reduction in hours <input type="checkbox"/> Leave of absence or medical leave	<b>Terminate Effective Date:</b> _____  <input type="checkbox"/> Deceased — Date of death _____ <input type="checkbox"/> Expired COBRA coverage <input type="checkbox"/> Enrolled in error <input type="checkbox"/> Gross misconduct (not COBRA eligible) <input type="checkbox"/> Group Open Enrollment (only applies to vision) <input type="checkbox"/> Other _____

List all Members enrolled (Primary member must be enrolled for dependents to remain enrolled)			Terminations
PRIMARY MEMBER'S FIRST NAME, LAST NAME	<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate
SPOUSE/DOMESTIC PARTNER'S FIRST NAME, LAST NAME	<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate
CHILD'S FIRST NAME, LAST NAME	<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate
CHILD'S FIRST NAME, LAST NAME	<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate
CHILD'S FIRST NAME, LAST NAME	<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate
CHILD'S FIRST NAME, LAST NAME	<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate

COBRA Information		
<b>Our group is:</b>	<b>If your company is.....</b>	<b>Then COBRA is administrated by....</b>
<input type="checkbox"/> <b>Federal COBRA Eligible</b>	If your company employed 20 or more employees for the majority of the last calendar year.	Benefits must be administered by the Employer. If a member has declined Federal COBRA benefits OR if you are not yet sure whether they want the benefits, check "Member has NOT elected Fed-COBRA" box above. Member has 60 days to elect coverage, at which time a new Enrollment Form should be faxed to HealthSmart.
<input type="checkbox"/> <b>State COBRA Eligible</b>	If your company employed 19 or fewer employees for the majority of the last calendar	Benefits will be administered by HealthSmart if member elects. Please provide us with the member's mailing address and we will mail the necessary paperwork.

Federal COBRA (Mandatory for groups subject to Federal COBRA only)	
<input type="checkbox"/> Member has elected Federal COBRA	<input type="checkbox"/> Member has NOT elected Federal COBRA (Member is still in election period or has declined election)

Please fill out completely and submit to HealthSmart within 30 days of termination. If HealthSmart does not receive timely termination information, the member will remain on the invoice and the employer will be responsible for all premiums and fees due for the timeframes outside of the 30-day window.