KAISER PERMANENTE CHOICE SOLUTION

A *CHOICE* Administrators® Program

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Employee Termination Notification Form

For Termination of Employment, Reduction of Hours, Loss of Life

Company Name

Group #

Complete this form when there is a termination of employment, reduction of hours or loss of life. Coverage will end on the last day of the month following each event.*

1

Employee Last Name

Employee First Name

Employee Social Security Number

*Last Day Employed or Eligible
MO   DAY   YEAR

Reason:
- ○ *Resignation of employment*
- ○ *Involuntary employment termination***
- ○ *Hours reduced - no longer eligible*
- ○ *Deceased*

2

Employee Last Name

Employee First Name

Employee Social Security Number

*Last Day Employed or Eligible
MO   DAY   YEAR

Reason:
- ○ *Resignation of employment*
- ○ *Involuntary employment termination***
- ○ *Hours reduced - no longer eligible*
- ○ *Deceased*

3

Employee Last Name

Employee First Name

Employee Social Security Number

*Last Day Employed or Eligible
MO   DAY   YEAR

Reason:
- ○ *Resignation of employment*
- ○ *Involuntary employment termination***
- ○ *Hours reduced - no longer eligible*
- ○ *Deceased*

**Involuntary termination of employment includes but is not limited to layoffs, job elimination and termination for cause.

FORM MUST BE SIGNED & DATED

→

_____
Group Plan Administrator Signature

_____
Print Name

_____
Date

General Guidelines

- Please do not send a cancellation request prior to the actual last day of employment or eligibility
- Coverage will cease at the end of the month following the last day of employment or eligibility
- Written notification must be received within 30 days of the event
- *CHOICE* Administrators® will only give retroactive credit if notification was received within the guidelines provided
- Voluntary termination of coverage for employees and/or dependents must be submitted on a change request form. (Coverage will cease at the end of the month following receipt of a completed form.)
- Dependent qualifying events should be submitted on a dependent qualifying event form. (Coverage will cease at the end of the month following the event provided written notification is given within 60 days of the qualifying event.)

This document should be faxed to *CHOICE* Administrators® for immediate attention

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