EMPLOYEE TERMINATION FORM

Company Name:					Group #:	

Employee Name	DOB	EE Cert # (Located on Bill)	Termination Date	Coverage Type	Reason for Term	Cal Cobra* (Y/N)

*If Cal Cobra election packets need to be sent to the employee or qualified beneficiary, please indicate the reason for termination (i.e. Involuntary termination, voluntary termination, death). This will ensure that the proper packet is sent to the employee or qualified beneficiary.

Signature:	Date: