ADA/COBRA ADMINISTRATION TERMINATION REQUEST FORM

Note: If terminating BCN coverage, a BCN termination form must accompany this document.

Dealership Name_____ Phone_____

	Insurance Carrier	Group Number	Premium: at Termination	Single Person Rate
Health	_____	_____	$ _____/month	$ _____/month
Prescr	_____	_____	$ _____/month	$ _____/month
Dental	_____	_____	$ _____/month	$ _____/month
Vision	_____	_____	$ _____/month	$ _____/month
Other	_____	_____	$ _____/month	$ _____/month

Employee Name_____ _____
Last Name First Name MI

Address_____ _____
Street P.O. Box/Apt. #

_____ _____ _____ Phone (____) ____-_____
City State Zip Code

____/____/____ ____-____-____ ____/____/____
Date of Birth Social Security Number Hire Date

COBRA Qualifying Event

- ☐ Voluntary Termination
- ☐ Involuntary Termination
- ☐ Layoff
- ☐ Reduced Hours
- ☐ Retirement
- ☐ Medicare Entitlement
- ☐ Death
- ☐ Divorce/Separation
- ☐ Ineligible Dependent
- ☐ FMLA Exhaustion
- ☐ Leave of Absence
- ☐ Other_____

Qualifying Event Occurred ____/____/____ **Loss of Coverage Date** ____/____/____

Has this employee or any qualified dependent been determined disabled by the Social Security Administration? ☐Yes ☐No

Dependents covered at Qualifying Event *(If more than four dependents, use back of form and check here ☐)*

Name	Relationship (circle one)	Date of Birth	Social Security Number
_____	(Husband/Wife/Son/Daughter)	____/____/____	____-____-____
_____	(Husband/Wife/Son/Daughter)	____/____/____	____-____-____
_____	(Husband/Wife/Son/Daughter)	____/____/____	____-____-____
_____	(Husband/Wife/Son/Daughter)	____/____/____	____-____-____

Spouse address (if different than employee's)

Address_____ _____
Street P.O. Box/Apt. #

_____ _____ _____ Phone (____) ____-_____
City State Zip Code

_____ ____/____/____
Authorized Signature (of dealership representative) Title Date

ADA COBRA Administration Service
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