TERMINATION / QUALIFYING EVENT FORM

GROUP NAME: ___________________________________
GROUP #: ____________________

Please complete the following form and return via fax 574-296-9970 or mail to Security Administrative Services Call 1-800-550-4115 with questions.

PARTICIPANT INFORMATION

Participant Name ________________________________ Social Security # ________ - ________ - ________

Home Address: ____
Street Apt. No. City State Zip Code

TERMINATE ALL COVERAGE – QUALIFYING EVENT

Termination Date ____ / _____/ _______

Level of Coverage: ___ Single ___ Employee + Spouse ___ Employee + Children ___ Full Family

Type of Event: ______ Death of Employee ______ Divorce or Legal Separation

Termination: ______ Voluntary ______ Involuntary / Reason?: ________________________________

____

TERMINATE SPECIFIC COVERAGE – EMPLOYEE REQUEST

Termination Date ____ /_____/ ______

Termination Specific Coverage: ______ Medical ______ Dental ______ Life ______ STD

______ LTD ______ FSA **- If FSA see below *** _______ Vision

*** If FSA - Please include last pay date**: ___ / ____ / _____ **AND Accrued Amount** $ _______________

Reason for termination: ____

TERMINATE DEPENDENT COVERAGE

Termination Date ____ / ____ / ______ Type of Coverage: ____ Medical ____ Dental ____ FSA _____ Vision

Other: ____

RELATION:	NAME:	DATE OF BIRTH:	REASON:
SPOUSE			
CHILD			
CHILD			
CHILD			

SIGNATURE

Any termination of coverage requested by the Employee, requires the employees signature. I certify the statements and answers contained on this questionnaire are true and complete to the best of my knowledge.

X ________________________________ X ________________________________
Employee Signature Date Authorized Employer Signature Date