

TERMINATION / QUALIFYING EVENT FORM

GROUP NAME: _____

GROUP #: _____

Please complete the following form and return via fax 574-296-9970 or mail to Cornerstone Benefits Administrator, Inc. 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 *

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

Reason for termination: _____

TERMINATE DEPENDENT COVERAGE

Termination Date ____ / ____ / ____ Type of Coverage: ____ Medical ____ Dental ____ FSA

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 _____
Employee Signature Date

X _____
Authorized Employer Signature Date