



**COVERAGE TERMINATION REQUEST FORM**

**Directions:** If an employee needs to terminate their coverage, complete Section 1. If an employer needs to remove an employee from coverage due to termination of employment, complete Section 2.

**SECTION 1**

Employer Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Coverage(s) to be Terminated:

- Medical:**       Employee     Emp + Spouse     Emp + Child(ren)     Family
- Dental:**       Employee     Emp + Spouse     Emp + Child(ren)     Family
- Vision:**       Employee     Emp + Spouse     Emp + Child(ren)     Family
- Voluntary Life:**     Employee     Emp + Spouse     Emp + Child(ren)     Family

Reason for Termination: \_\_\_\_\_ Date Occurred: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION 2**

Employer Name: \_\_\_\_\_

Employee to be Removed from Plan: \_\_\_\_\_

Employee Terminated or Resigned:  Terminated     Resigned    Date Occurred: \_\_\_\_\_

Name of Administrator Requesting Termination: \_\_\_\_\_

Title of Administrator Requesting Termination: \_\_\_\_\_

Are you authorized to make changes to the TBA-sponsored plan(s) on behalf of the firm?  Yes     No

I acknowledge that the termination request submitted herein is complete and accurate, and that I am authorized to act on behalf of the employer in making changes to the group's coverage. I understand that incomplete or inaccurate information may delay processing.

Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ADDITIONAL INFORMATION**

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