Enrollment Termination Form

This form is to notify the **Association Insurance Benefits Program** that the employee listed below has experienced a Qualifying Event and is no longer eligible for plan coverage.

NOTIFICATION MUST BE MADE WITHIN 30 DAYS OF THE QUALIFYING EVENT

Section A: Company Information				
Name of Company:			Employer Phone Number: ( )	
Company Contact Name:			Contact Email Address:	
Section B: Employee Information				
Employee Last Name	Employee First Name		Employee Social Security Number — —	
Residence Address	Apt #	City	State	Zip Code
Dependent Address (if different from Employee)	Apt #	City	State	Zip Code
Section C: Qualifying Event Employment Termination Effective:		Coverage Termination Date:		
Section D: Type of Qualifying Event				
End of employment			❑	
Death of employee			❑	
Termination of employment for misconduct (no COBRA will be offered)			❑	
Entitlement to Medicare			❑	
Reduction in work hours			❑	
Divorce or legal separation			❑	
Loss of dependent child status			❑	
Section E: Coverages To Be Terminated ❑ Medical ❑ Dental ❑ Vision				
Section F: Employer/Authorized Signature _____ Employer Signature Date _____ Print Name Job Title				