North Ranch Benefits Trust
POWERED BY WARNER PACIFIC

Return form to:
HealthSmart Benefit Solutions, Inc.
Phone: (800) 786-6525 Fax: (303) 804-9490
Email: NRBT@healthsmart.com

HealthSmart
SMARTER HEALTHCARE SOLUTIONS

Member Termination Form

To be completed by the Benefits Administrator.

Group Information

COMPANY/GROUP NAME	GROUP #	
GROUP CONTACT PERSON	TITLE	
CONTACT EMAIL	CONTACT PHONE #	DATE
SIGNATURE OF AUTHORIZED GROUP CONTACT		

Member Information

MEMBER NAME (FIRST NAME, LAST NAME)		
SOCIAL SECURITY #	LAST DATE OF EMPLOYMENT OR LAST DAY OF COVERAGE (if applicable)	
MAILING ADDRESS **(Required)**		
CITY	STATE	ZIP CODE

Reason for Termination

Plan coverage to terminate: ☐ **Dental** ☐ **Vision**

Terminate Effective Date: ____________________

- ☐ **Voluntary termination of employment**
- ☐ **Obtained other coverage or covered through spouse**
- ☐ **Voluntary termination of coverage**
- ☐ **Involuntary termination of employment**
- ☐ **Reduction in hours**
- ☐ **Leave of absence or medical leave**
- ☐ **Deceased — Date of death** ____________________
- ☐ **Expired COBRA coverage**
- ☐ **Enrolled in error**
- ☐ **Gross misconduct (not COBRA eligible)**
- ☐ **Group Open Enrollment (only applies to vision)**
- ☐ **Other** ____________________

List all Members enrolled

(Primary member must be enrolled for dependents to remain enrolled)

Name	Gender	DATE OF BIRTH	Terminations
PRIMARY MEMBER'S FIRST NAME, LAST NAME	☐ **Male** ☐ **Female**	DATE OF BIRTH	☐ **Remain enrolled** ☐ **Terminate**
SPOUSE/DOMESTIC PARTNER'S FIRST NAME, LAST NAME	☐ **Male** ☐ **Female**	DATE OF BIRTH	☐ **Remain enrolled** ☐ **Terminate**
CHILD'S FIRST NAME, LAST NAME	☐ **Male** ☐ **Female**	DATE OF BIRTH	☐ **Remain enrolled** ☐ **Terminate**
CHILD'S FIRST NAME, LAST NAME	☐ **Male** ☐ **Female**	DATE OF BIRTH	☐ **Remain enrolled** ☐ **Terminate**
CHILD'S FIRST NAME, LAST NAME	☐ **Male** ☐ **Female**	DATE OF BIRTH	☐ **Remain enrolled** ☐ **Terminate**
CHILD'S FIRST NAME, LAST NAME	☐ **Male** ☐ **Female**	DATE OF BIRTH	☐ **Remain enrolled** ☐ **Terminate**

COBRA Information

Our group is:	**If your company is…..**	**Then COBRA is administrated by….**
☐ **Federal COBRA Eligible**	If your company employed 20 or more employees for the majority of the last calendar year.	Benefits must be administered by the Employer. If a member has declined Federal COBRA benefits OR if you are not yet sure whether they want the benefits, check "Member has NOT elected Fed-COBRA" box above. Member has 60 days to elect coverage, at which time a new Enrollment Form should be faxed to HealthSmart.
☐ **State COBRA Eligible**	If your company employed 19 or fewer employees for the majority of the last calendar	Benefits will be administered by HealthSmart if member elects. Please provide us with the member's mailing address and we will mail the necessary paperwork.

Federal COBRA (Mandatory for groups subject to Federal COBRA only)

☐ **Member has elected Federal COBRA**

☐ **Member has NOT elected Federal COBRA** (Member is still in election period or has declined election)

Please fill out completely and submit to HealthSmart within 30 days of termination. If HealthSmart does not receive timely termination information, the member will remain on the invoice and the employer will be responsible for all premiums and fees due for the timeframes outside of the 30-day window.