

Inshore Benefits

Employee Termination Form — Dental & Vision



Please fill out form completely and **submit within 30 days of qualifying event**. If this form is not received timely, the member will remain on the invoice and the employer will be responsible for premiums and fees due for the time frames outside of the 30 day window.

1. GROUP INFORMATION	
Company/Group Name:	Group/Billing Division #:
Group Contact Person:	Title:
Contact Email:	Contact Phone #:
Signature of Authorized Group Contact:	Today's Date:

2. MEMBER INFORMATION	
Member Name (First, Last):	Last four numbers of Social Security #:
Current Mailing Address (Required if State COBRA Eligible):	
City:	State: Zip Code:

3. SELECT REASON FOR TERMINATION	
Requested Termination Date:	All terminations will be within 30 days.
<input type="checkbox"/> Voluntary termination of employment - Date of Term:	<input type="checkbox"/> Deceased - Date of Death:
<input type="checkbox"/> Involuntary termination of employment - Date of Term:	<input type="checkbox"/> Expired COBRA coverage - End date of COBRA:
<input type="checkbox"/> Obtained other coverage or covered through spouse - Effective Date:	<input type="checkbox"/> Enrolled in error - term as never effective (must be within past 30 days)
<input type="checkbox"/> Voluntary termination of coverage - Date of Term:	<input type="checkbox"/> Gross misconduct (not COBRA eligible) - Date of Term:
<input type="checkbox"/> Reduction in hours - Date of Reduction:	<input type="checkbox"/> Other - Explain and Date of Term:

4. LIST ALL FAMILY MEMBERS ENROLLED				
Primary member must be enrolled for dependents to remain enrolled.			Dental	Vision
Primary Member's Name (First, Last):	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate
Spouse/Domestic Partner's Name (First, Last):	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate
Child's Name (First, Last):	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate
Child's Name (First, Last):	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate
Child's Name (First, Last):	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate
Child's Name (First, Last):	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate	<input type="checkbox"/> Remain enrolled <input type="checkbox"/> Terminate

5. COBRA INFORMATION			
Our group is:	If your company...	Then Cobra is administrated by...	Select one, if applicable:
<input type="checkbox"/> State COBRA eligible	Employed 19 or fewer employees for the majority of the last calendar year.	Benefits may be administered by Pathian Administrators depending on the states rules in the state the group is headquartered in. Check with your state's Department of Labor for continuation guidelines.	<input type="checkbox"/> Please send State COBRA offer to terminated member, if applicable in my state. <input type="checkbox"/> In our state, it is the employer's responsibility to send out the State COBRA offer. <input type="checkbox"/> Member has elected State COBRA. Member should remain on our invoice as a State COBRA member. <input type="checkbox"/> Member has NOT elected State COBRA. Member is still in election period or has declined election.
<input type="checkbox"/> Federal COBRA eligible	Employed 20 or more employees for the majority of the last calendar year.	Benefits are administered by the employer. Member has 60 days to elect coverage, at which time a new enrollment form should be faxed to Pathian Administrators.	<input type="checkbox"/> Member has elected Federal COBRA. Member should remain on our invoice as a Federal COBRA member. <input type="checkbox"/> Member has NOT elected Federal COBRA. Member is still in election period or has declined election.

Signature of authorized company representative: _____ Date: _____

Please print name: _____

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