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.
☐ Voluntary termination of employment - Date of Term:	☐ Deceased - Date of Death:
☐ Involuntary termination of employment - Date of Term:	☐ Expired COBRA coverage - End date of COBRA:
☐ Obtained other coverage or covered through spouse - Effective Date:	☐ Enrolled in error - term as never effective (must be within past 30 days)
☐ Voluntary termination of coverage - Date of Term:	☐ Gross misconduct (not COBRA eligible) - Date of Term:
☐ Reduction in hours - Date of Reduction:	☐ 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):	☐ Male ☐ Female	Date of Birth:	☐ Remain enrolled ☐ Terminate	☐ Remain enrolled ☐ Terminate
Spouse/Domestic Partner's Name (First, Last):	☐ Male ☐ Female	Date of Birth:	☐ Remain enrolled ☐ Terminate	☐ Remain enrolled ☐ Terminate
Child's Name (First, Last):	☐ Male ☐ Female	Date of Birth:	☐ Remain enrolled ☐ Terminate	☐ Remain enrolled ☐ Terminate
Child's Name (First, Last):	☐ Male ☐ Female	Date of Birth:	☐ Remain enrolled ☐ Terminate	☐ Remain enrolled ☐ Terminate
Child's Name (First, Last):	☐ Male ☐ Female	Date of Birth:	☐ Remain enrolled ☐ Terminate	☐ Remain enrolled ☐ Terminate
Child's Name (First, Last):	☐ Male ☐ Female	Date of Birth:	☐ Remain enrolled ☐ Terminate	☐ Remain enrolled ☐ Terminate

5. COBRA INFORMATION			
Our group is:	**If your company...**	**Then Cobra is administrated by...**	**Select one, if applicable:**
☐ 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.	☐ Please send State COBRA offer to terminated member, if applicable in my state. ☐ In our state, it is the employer's responsibility to send out the State COBRA offer. ☐ Member has elected State COBRA. Member should remain on our invoice as a State COBRA member. ☐ Member has NOT elected State COBRA. Member is still in election period or has declined election.
☐ 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.	☐ Member has elected Federal COBRA. Member should remain on our invoice as a Federal COBRA member. ☐ 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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