

Notification of Termination of Employee/Coverage

Please submit to us **by fax (800)311-2100** or by mailing to **379 Diablo Road, Suite 101, Danville, CA 94526**.

Please do not submit with premium payment, this will delay the processing of the termination.

To add or delete a dependent, a status change on application needs to be completed and submitted.

Company: _____ Builders Exchange: _____

Employee to be Terminated:

**** IMPORTANT ****

Due to Federal COBRA/Cal-COBRA Regulations, please ensure that you provide the **last known address** for the employee below. Your Human Resources or Payroll Department may have the most current information.

Employee Name: _____ Social Security #: _____

Street Address City State Zip

Name of Qualified Beneficiaries: _____

Address of Qualified Beneficiaries, if different from Employee Address:

Street Address City State Zip

Last day of employment or date of qualifying event: _____

Coverage Termination date: (This is the 1st day of the month following the last day worked.)

mm/dd/yy
/ 01 /

Reason for termination of coverage:

- Termination of employment Reduction in hours of employment Death of employee
 Employee's Medicare Entitlement Military Leave Other: _____

Coverage(s) to be terminated:

- Health Dental Vision Chiropractic Basic Life Optional Life

Coverage type:

- Employee Employee + Child(ren) Employee + Spouse Employee + Family

Employer/Contact Person Signature

Print Name

Date

For Administrator's Use Only

- COBRA Eligible (20 + employees) CAL-COBRA Eligible (2-19 employees) COBRA/CAL-COBRA Ineligible

14th Day from Received Date: _____

Date Mailed: _____

Acct. Mgr. Initials: _____