

# Employee Termination of Insurance Form

Please submit to us **by fax (206) 859-2638** or by mailing to **CBX c/o BSI, PO Box 6, Mukilteo, WA 98275**.

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

To add or delete a dependent, an Insurance Change Request Form must be submitted.

To cancel coverage (health, dental, vision and/or life) for an active employee, a Declination Form must be submitted.

## EMPLOYEE TERMINATION

This form is to notify **Q & A Insurance Marketing, Inc.** and **Benefit Solutions, Inc.** 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 event.*

Company	Builders Exchange/Association	Date	
<b>** IMPORTANT **</b>			
Due to Federal COBRA/Cal-COBRA Regulations, please ensure that you provide the <b>last known address</b> for the employee and all enrolled dependents below. Your Human Resources or Payroll Department may have the most current information.			
Employee Name	Social Security #		
Street Address	City	State	Zip
ADDRESS OF ANY DEPENDENT IF DIFFERENT THAN EMPLOYEE'S ADDRESS			
Dependent Name			
Dependent Address *	City	State	Zip

\* If a Qualified Medical Support Order is in force, please supply name and address of Support Agency.

## QUALIFYING EVENT

EMPLOYMENT TERMINATION EFFECTIVE DATE: \_\_\_\_\_

COVERAGE TERMINATION DATE: \_\_\_\_\_ (The 1<sup>st</sup> day of the month on or following the qualifying event)

**Coverage(s) to be terminated:**    Dental    Vision    Life    CADR+    LifeLock

### Qualifying Event

- Voluntary termination of employment** (resignation, retirement)
- Involuntary termination of employment** (layoff, employee terminated)
- Termination of employment for Gross Misconduct** (no COBRA will be offered, Legal advise is strongly suggested)
- Employee's Medicare Entitlement**
- Death of Employee**
- Reduction in work hours**
- Military leave**
- Leave of absence**
- Other:** \_\_\_\_\_

EMPLOYER / AUTHORIZED SIGNATURE

DATE

Print Name

Job Title

### For Administrator's Use Only

COBRA Eligible	CAL-COBRA Eligible	Ineligible
14 <sup>th</sup> Day from Received Date:	Date Notice Mailed:	Acct. Mgr. Initials: