

COVERAGE TERMINATION REQUEST FORM

Directions: If an employee needs to terminate their coverage, complete Section 1. If an employer needs to remove an employee from coverage due to termination of employment, complete Section 2.

SECTION 1

Employer Name: _____

Employee Name: _____

Coverage(s) to be Terminated:

Medical: Employee Emp + Spouse Emp + Child(ren) Family

Vision: Employee Emp + Spouse Emp + Child(ren) Family

Voluntary Life: Employee Emp + Spouse Emp + Child(ren) Family

Reason for Termination: _____ Date Occurred: _____

Employee Signature: _____ Date: _____

SECTION 2

Employer Name: _____

Employee to be Removed from Plan: _____

Employee Terminated or Resigned: Terminated Resigned Date Occurred: _____

Name of Administrator Requesting Termination: _____

Title of Administrator Requesting Termination: _____

Are you authorized to make changes to the TDA-sponsored plan(s) on behalf of the practice? Yes No

I acknowledge that the termination request submitted herein is complete and accurate, and that I am authorized to act on behalf of the employer in making changes to the group's coverage. I understand that incomplete or inaccurate information may delay processing.

Administrator Signature: _____ Date: _____

ADDITIONAL INFORMATION

