

COBRA TERMINATION FORM

Form must be completed in full to process.

Click SUBMIT at the end of this form to send by email,
or print and fax to Jill Polinski at 612.436.5602. Questions? 612.436.5631

- Coverage will terminate the last day of the month the event happened.
- There will be no letter sent out to member, but coverage will be terminated.
- Employer responsible to check billing and notify corrections.

Please complete all areas that relate to this individual:

EMPLOYER

Name
Address
City
Phone

Your Name

State Zip

EMPLOYEE OR DEPENDENT'S NAME & ADDRESS

Date of Change
Employee Name
Date of Birth
Soc. Sec. #

Spouse & Children information required if covered under insurance plan

Spouse Date of Birth

Number of Children

REASON FOR COBRA TERMINATION

- Non-Payment
- 18/36 months exhausted
- Cancelling COBRA coverage
- Moving to spouse's plan
- Other group coverage now available
- Disability
- Medicare

CURRENT COBRA COVERAGE

Employee Health

Insurance Company

Type of coverage (click all that apply):

Employee Spouse

Children
Group Number

Employee Dental

Insurance Company

Type of coverage (click all that apply):

Employee Spouse

Children
Group Number

Employee Life

Insurance Company

Type of Coverage (click all that apply):

Employee

Group Number

SUBMIT

Click this button to email this form to Jill Polinski: jpolinski@bearence.com