**Call/Fax:**
**Tel: 888-292-0272**
**FAX: 312-416-2860**
**E-mail:**
NGBS.MemberTermination@alliedbenefit.com

**Please complete and return via FAX or E-mail**

## FORM INSTRUCTIONS

*Please complete the form and submit to Allied within 30 days of a member coverage termination. Member terminations submitted greater than 90 days retroactively will be subject to additional review.*

## EMPLOYER INFORMATION

**Group Name**

**Group Number**

## EMPLOYEE INFORMATION

| **Employee Name** | | |
|---|---|---|
| **Last** | **First** | **Middle Initial** |

| **Employee Social Security Number** | | **Employee Date of Birth** | **MM** | **DD** | **CCYY** |
|---|---|---|---|---|---|

| **Employee Address** | **City** | **State** | **Zip Code** |
|---|---|---|---|

## TERMINATION INFORMATION

| **Date of Insurance Term** | **Coverage Termination Date (last day covered under the plan):**<br>MM DD CCYY<br>**Please note that if the first day of the month is listed above then we will terminate to the last day of the previous month**<br>*Coverage termination date should be on the 14th or last day of month depending on the group's policy effective date |
|---|---|

**Qualifying Event Reason (Must select only one)**

| | | | |
|---|---|---|---|
| ☐Employee's Termination or Employee's Layoff | ☐Spouse's Divorce or Legal Separation from Employee | ☐Employee's Death | ☐Dropping Coverage (specify on form which member is to be termed) |
| ☐Dependent Child Ceasing to Qualify Under the Plan | ☐Terminate back to coverage effective date (no coverage under the plan) | ☐Medicare Entitlement | |
| | | ☐Open Enrollment | ☐Employee's Reduction in Hours |

Special Notes: ______________________________________________

______________________________________________

**If a Termination of Employment was the Qualifying Event, please indicate whether the Termination was Voluntary or Involuntary:**

☐Involuntary ☐Voluntary

## EMPLOYEE/DEPENDENTS TO BE TERMINATED

**Confirm below all participants that are to be terminated**

| Employee Name | Relationship | Gender | Birthdate (MM/DD/YYYY) | Social Security Number |
|---|---|---|---|---|
| | **Employee** | ☐M ☐F | | |
| **Dependent Name(s)** | | | | |
| | Spouse | ☐M ☐F | | |
| | Child | ☐M ☐F | | |
| | Child | ☐M ☐F | | |
| | Child | ☐M ☐F | | |
| | Child | ☐M ☐F | | |

## AUTHORIZATION

I certify that the above information is accurate. *If applicable*, I authorize Allied Benefit Systems, Inc. to notify those individuals whom I have certified of their COBRA rights and creditable coverage.

______________________________________________ Signature of Authorized Company Representative

______________________________ Date

| NGBS Office Use Only | Applicable if requested term date above is prior to 90-days from the termination submission date<br><br>Approved Term Date / /20 | Approved By ______________________ |
|---|---|---|