ALLIED

**Call/Fax:**
**Tel: 888-292-0272**
**FAX: 312-416-2860**
**E-mail:**
ABSF.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):**

MM DD CCYY

**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**

*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, LLC to notify those individuals whom I have certified of their COBRA rights and creditable coverage.

_____ _____

Signature of Authorized Company Representative Date

| ABSF 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 _____ |
|---|---|---|