PUBLIC EMPLOYEES INSURANCE PROGRAM

TERMINATION FORM

QUALIFYING BENEFICIARY DATA

Employer Name: _____

Name: _____ Social Security No: _____
Last First MI

Address: _____
Street City State Zip

Phone No.: (_____) _____ Date of Birth: ____/_____/_____ Relationship to Employee: _____

EMPLOYEE DATA

Name: _____ Social Security No: _____
Last First MI

QUALIFYING EVENT

Event Date: _____/_____/_____ Last Day of Coverage: _____/_____/_____

For Employee:

_____ Termination of Employment _____ Reduction in Hours _____ Non-Medical Leave of Absence

_____ Work Related Disability _____ Non-Work Related Disability _____ Early Retirement

For Dependent:

_____ Death of Covered Employee _____Divorce or Legal Separation _____ Employee's Entitlement to Medicare

_____ Child's Loss of Dependent Status

HEALTH PLAN COVERAGE

Medical Plan: _____ ____ Single ____ Family

Dental Plan: _____ ____ Employee + Spouse ____ Employee + Child

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