benefit strategies LLC

Partners HealthCare COBRA Termination Request Form

Instructions: **Please *completely* fill out this form to request for COBRA Termination. Incomplete, incorrect and/or illegible forms will be returned back to the sender and require a new form submission. Print and send completed form and send via email, fax or paper mail.**

Email: PartnersInfo@benstrat.com **Fax: (603) 232-6275**

Benefit Strategies, LLC
PO Box 3938
Manchester, NH 03105-3938
Phone: (844) 777-7870

1. Employee or Qualified COBRA Beneficiary (QB) Information:

Employee/QB Full Name:_____

Previous Employer Name:_____

Employee/QB last 4 of SSN:_____ **(OR) Employee/QB Date of Birth:**_____

Employee/QB Email:_____ **Employee/QB Phone:**_____

2. Benefit Termination Information:

Check off all boxes that apply to your request. We will only process 30 day retroactive termination requests.

	Benefit	**Effective Date**	**Terminate Coverage for ALL Covered**	**Name of Individual(s) to Terminate**
☐	**All Benefits**		☐	
☐	**Medical**		☐	
☐	**Dental**		☐	
☐	**Vision**		☐	
☐	**Other**		☐	
***Reason**				

*If termination is due to death, please provide a copy of the death certificate.

If termination is due to Medicare entitlement, please provide a copy of the Medicare card showing your Part B effective date IF ONLY dependent(s) are staying on COBRA.

I do not want to continue coverage for any dependents on my plan(s): ☐

3. Continuing Dependent(s) Coverage:

ONLY if you wish to continue coverage for one or more of your dependent(s), please fill out the information below.

Full Name: _____ Relationship: ☐Spouse ☐Dependent Child

Date of Birth: _____ Full SSN: _____

Check off all that apply: ☐ Medical ☐Dental ☐ Vision ☐Other: _____

Full Name: _____ Relationship: ☐Spouse ☐Dependent Child

Date of Birth: _____ Full SSN: _____

Check off all that apply: ☐ Medical ☐Dental ☐ Vision ☐Other: _____

Full Name: _____ Relationship: ☐Spouse ☐Dependent Child

Date of Birth: _____ Full SSN: _____

Check off all that apply: ☐ Medical ☐Dental ☐ Vision ☐Other: _____

4. Signature:

I understand this submission is a request to terminate my COBRA coverage for the specific benefit(s) indicated above. Any incomplete or illegible forms will be returned and I am required to submit a new form for completion of my request. I understand this process can take up to 14 business days and it is my responsibility to confirm with the insurance carrier(s) the termination(s) have been processed.

Employee/QB Signature: _____ Date:_____