Termination Request Form

benefit strategies LLC

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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.

Employee or Qualified COBRA Beneficiary (QB) Information:

Employee/QB Name:
First/Last

Previous Employer Name:
First/Last

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

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

Benefit Termination Information:

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

Benefit	Termination 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 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): ☐

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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.

Name: First/Last — **Relationship:** ☐ Spouse ☐ Dependent Child

Date of Birth: MM/DD/YYYY — **Full SSN:**

Check Off All That Apply: ☐ Medical ☐ Dental ☐ Vision ☐ Other:

Name: First/Last — **Relationship:** ☐ Spouse ☐ Dependent Child

Date of Birth: MM/DD/YYYY — **Full SSN:**

Check Off All That Apply: ☐ Medical ☐ Dental ☐ Vision ☐ Other:

Name: First/Last — **Relationship:** ☐ Spouse ☐ Dependent Child

Date of Birth: MM/DD/YYYY — **Full SSN:**

Check Off All That Apply: ☐ Medical ☐ Dental ☐ Vision ☐ Other:

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: MM/DD/YYYY

Print and Sign →