

Employee Termination Notification Form

For Termination of Employment, Reduction of Hours, Loss of Life



CaliforniaChoice 51+
Your Health. Your Choice.®

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Company Name <input style="width:95%;" type="text"/>	Group # <input style="width:95%;" type="text"/>
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Complete this form when there is a termination of employment, reduction of hours or loss of life. Coverage will end on the last day of the month following each event.

1 Employee Last Name <input style="width:98%;" type="text"/>	Employee First Name <input style="width:98%;" type="text"/>
Employee Social Security Number <input style="width:30%;" type="text"/> <input style="width:30%;" type="text"/> <input style="width:30%;" type="text"/>	Last Day Employed or Eligible <input style="width:15%;" type="text"/> / <input style="width:15%;" type="text"/> / <input style="width:15%;" type="text"/> <small>(mo/day/year)</small>
Reason: <input type="radio"/> Employment terminated <input type="radio"/> Hours reduced, no longer eligible <input type="radio"/> Deceased	

2 Employee Last Name <input style="width:98%;" type="text"/>	Employee First Name <input style="width:98%;" type="text"/>
Employee Social Security Number <input style="width:30%;" type="text"/> <input style="width:30%;" type="text"/> <input style="width:30%;" type="text"/>	Last Day Employed or Eligible <input style="width:15%;" type="text"/> / <input style="width:15%;" type="text"/> / <input style="width:15%;" type="text"/> <small>(mo/day/year)</small>
Reason: <input type="radio"/> Employment terminated <input type="radio"/> Hours reduced, no longer eligible <input type="radio"/> Deceased	

3 Employee Last Name <input style="width:98%;" type="text"/>	Employee First Name <input style="width:98%;" type="text"/>
Employee Social Security Number <input style="width:30%;" type="text"/> <input style="width:30%;" type="text"/> <input style="width:30%;" type="text"/>	Last Day Employed or Eligible <input style="width:15%;" type="text"/> / <input style="width:15%;" type="text"/> / <input style="width:15%;" type="text"/> <small>(mo/day/year)</small>
Reason: <input type="radio"/> Employment terminated <input type="radio"/> Hours reduced, no longer eligible <input type="radio"/> Deceased	

Form must be signed & dated

_____ Group Plan Administrator Signature	_____ Print Name	_____ Date
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General Guidelines

- Please do not send a cancellation request prior to the actual last day of employment or eligibility
- Coverage will cease at the end of the month following the last day of employment or eligibility
- Written notification must be received within 30 days of the event
- CaliforniaChoice **51+** will only give retroactive credit if notification was received within the guidelines provided
- Voluntary termination of coverage for employees and/or dependents must be submitted on a Change Request form. (Coverage will cease at the end of the month following receipt of a completed form.)
- Dependent qualifying events should be submitted on a Dependent Qualifying Event form. (Coverage will cease at the end of the month following the event provided written notification is given within 60 days of the qualifying event.)

This document should be faxed to CaliforniaChoice 51+ for immediate attention