Return Completed Form to:
ABGHfullyinsured@ngic.com

ALLSTATE BENEFITS SECURE CHOICE MEMBER TERMINATION FORM INSTRUCTIONS

Please complete the form and submit to Allstate Benefits no later than the last day of the billing month of the requested termination date. Retro terminations are not allowed. Please return via E-mail.

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 Member Insurance Termination	**Coverage Termination Date (last day covered under the plan):** MM DD CCYY ***IMPORTANT INFORMATION:*** ***When the Coverage Termination Date is listed as the first day of the month, then coverage termination date recorded will be 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* ☐ Terminate Back to Coverage Effective Date (No coverage under the plan) ☐ Spouse's Divorce or Legal Separation from Employee* ☐ Dependent Child Ceasing to Qualify Under the Plan ☐ Dropping Coverage (Specify on form which member is to be terminated)	☐ Employee Reduction in Hours ☐ Employee's Death* ☐ Termination of Plan* (COBRA only) ☐ Retirement* (COBRA only) ☐ Medicare Entitlement ☐ Open Enrollment

**Indicates Qualifying Event Reason is Eligible for State Continuation or COBRA coverage*

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 all participants that are to be terminated below

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**		

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 or State Continuation Rights and creditable coverage.

_____ _____

Signature of Authorized Company Representative Date

AFI Office Use Only	Applicable if requested term date above is prior to 30-days from the termination submission date	Approved Term Date ____/_____/20__ Approved By _____

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