ALLIED

Call/Fax:
Tel: 888-292-0272
FAX: 312-416-2860
E-mail:
NWSF.MemberTermination@alliedbenefit.com

Please complete and return via FAX or E-mail

FORM INSTRUCTIONS

Please complete the form and submit to Allied within 30 days of a member coverage termination. Member terminations submitted greater than 90 days retroactively will be subject to additional review.

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 Insurance Term

Coverage Termination Date (last day covered under the plan):

MM DD CCYY

Please note that if the first day of the month is listed above then we will terminate to 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	☐Spouse's Divorce or Legal Separation from Employee	☐Employee's Death	☐Dropping Coverage (specify on form which member is to be termed)
☐Dependent Child Ceasing to Qualify Under the Plan	☐Terminate back to coverage effective date (no coverage under the plan)	☐Medicare Entitlement	
		☐Open Enrollment	☐Employee's Reduction in Hours

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 below all participants that are to be terminated

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		
	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 rights and creditable coverage.

_____ _____

Signature of Authorized Company Representative Date

NWSF Office Use Only	Applicable if requested term date above is prior to 90-days from the termination submission date Approved Term Date / /20	Approved By _____