Call/Fax:
Tel: 888-292-0272
FAX: 312-416-2860
E-mail:
ABSF.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

ABSF 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 ______________