Termination Notice

Benefit coverage(s) will end on the last day of the month following termination, as long as notice is received within 30 days of the termination date. *EXAMPLE: Last day of employment is Jan. 13; coverage will end Jan. 31.*

□ **UT Main Campus** _____ _____

Carrier

□ **UT Health Science Campus** **Paramount / MMO AFSCME OR BX**

Carrier (Please Circle)

_____

Employee Name **Social Security Number**

Terminate: ☐ **Employee & Dependent(s)** ☐ **Dependent(s) (List Below)**

Last day of Coverage: _____

Please Select the Appropriate Reason Code And Clearly Circle It.

1. **Left Employment** (☐ **Voluntary Termination** ☐ **Involuntary Termination)**
2. **Loss of Dependent Status**
3. **Divorce or Legal Separation**
4. **Other Insurance**
5. **Non-Payment**
6. **Covered by Medicare**
7. **Reduced Work Hours**
8. **Marriage**
9. **Deceased**
10. **Open Enrollment**

Dependent's Name(s)*	**Social Security #**
Spouse:	

Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against a Benefit plan(s), submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud under state criminal law.

Please list address for COBRA information to be sent:

_____

Street address ***City*** ***State*** ***Zip Code***

X_____

Employee's Signature **Date**

Rocket # _____ **MEDICAL** _____ **RX** _____ **VISION** _____ **DENTAL** _____

MSA _____ **DSA** _____ **Basic Life and AD&D** _____

Dep. Life _____ **Vol. EE Life** _____ **Vol. Spouse Life** _____ **Vol. Child Life** _____ **Supp. Life** _____

Faculty **Resident** **Current Hire:** _____