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 / Aetna**
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:** _____