



TERMINATION AND COBRA REQUEST FORM

1. General Information:

Today's Date _____

Employer: _____

Employee's Name: _____
(Last) (First)

Employee's Address: _____

Employee's Soc. Sec. Number _____ - _____ - _____

2. Termination Request: Please mark the appropriate coverage(s).

- | | | |
|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> All Coverage | <input type="checkbox"/> Health | <input type="checkbox"/> Dental |
| <input type="checkbox"/> All Options | <input type="checkbox"/> Vision | <input type="checkbox"/> STD |
| <input type="checkbox"/> BTL | <input type="checkbox"/> Survivor Income | <input type="checkbox"/> HIB |
| <input type="checkbox"/> LTD | <input type="checkbox"/> LTDC | <input type="checkbox"/> Flex |
| <input type="checkbox"/> GTL | <input type="checkbox"/> College Fund | <input type="checkbox"/> Other _____ |

Reminder: Employees covered by life insurance should be offered conversion privileges.

Termination Date: ____/____/____ Coverage through End of Month Yes No

3. COBRA Information: Please check the Qualifying Event

- | | | |
|--|--|--|
| <input type="checkbox"/> Termination | <input type="checkbox"/> Death | <input type="checkbox"/> Bankruptcy - CHP 11 |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Ineligible Child | <input type="checkbox"/> Divorce or Legal Separation |
| <input type="checkbox"/> Term/Ret/Medicare | <input type="checkbox"/> Reduced Hours | <input type="checkbox"/> Other (Check one below) |
| <input type="checkbox"/> Medical Leave | <input type="checkbox"/> Leave of Absence | |
| <input type="checkbox"/> Layoff | <input type="checkbox"/> Loss in Eligibility of Coverage | |

4. Dependent Information: * (Section 4 should only be filled out when termination of dependent is the Qualifying Event.)

Dependent's Name: _____

Dependent's Address: _____

Dependent's Soc. Sec. Number _____ - _____ - _____ Date of Birth ____/____/____

Completed By: _____ Date: _____

Employee Signature _____ Date _____

If Employee or Dependent is interested in converting to an individual policy with BCBSM, please contact our office for the appropriate

This form must be mailed within 48 hours of the qualifying event.

MEBS OFFICE USE ONLY

Entered: _____

By: _____

Mail to: MEBS, Inc.
3809 Lake Eastbrook
Grand Rapids, MI 49546
(616) 458-6327
(800) 968-6327