Employee Termination Report

Date_____

Employer's Company Name _____

Address _____

Bill/Sub-Group Name _____ Location Code _____

Group I.D. _____ Bill/Sub-Group I.D. _____

Please list below the names of those employees who are no longer employed by your firm and no longer eligible for coverage. Please submit your terminations immediately. If applicable, credit will be limited according to your master policy/contract. If changes are not received within five working days of the date your billing statement is produced, the changes will appear on your subsequent billing statement. These changes may also be made through access to Web enrollment. If you should have any questions regarding Web enrollment, please call the toll-free customer service number located on the front of your billing statement.

Soc. Sec./I.D. No.	Employee's Name	Day Last Worked	Reason*

*If employee coverage ends for reason other than termination of employment, please give explanation in "Reason" column. If coverage ends other than "Day Last Worked," please give the date coverage should end and an explanation in "Reason" column.

Prepared By _____

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