Termination Form

CORNERSTONE PREFERRED RESOURCES

Section I: Employee (Subscriber) Information

Employee (Subscriber) Legal Name (Last, First)	Member ID	DOB

Section II: Terminating Coverage

This is to confirm that I elect to terminate participation in my employer's group health plan as indicated below. Please check all that apply.

Type of coverage being terminated	☐ Medical	☐ Dental	☐ Vision
Who is coverage being terminated for? *If **Self** is checked, spouse and dependent will also be terminated*	☐ Self (Subscriber) ☐ Spouse ☐ Dependent(s)	☐ Self (Subscriber) ☐ Spouse ☐ Dependent(s)	☐ Self (Subscriber) ☐ Spouse ☐ Dependent(s)

Legal name of employee (subscriber) to be terminated (Last, First)

Subscriber's last day of employment*

Termination is last day of the month of last date of employment.

Legal name of spouse to be terminated (Last, First)

For termination date, give the last day of the month of termination*

Legal name of dependent to be terminated (Last, First)

For termination date, give the last day of the month of termination*

Attach extra page if needed for addtn'l dependents

**Example: If last date of employment is June 5 or termination requested is June 5, then subscriber, spouse or dependent termination will be June 30.*

Section III: Terminating Information

Please submit employee and/or dependent terminations as they occur

Under the Affordable Care Act, a cancellation or discontinuance of health coverage that has a retroactive effect is not allowed in the absence of fraud, intentional misrepresentation of a material fact, or failure to pay required contributions timely. Even if it was an administrative error to allow an individual to remain on the plan, if that individual was allowed to continue to pay premiums, it is unlikely that coverage can be canceled retroactively.

☐ **Yes** ☐ **No** **If requested termination date is more than 30 days from the date this form was signed; did the employee (subscriber) pay any premium for health benefits coverage after the last day of the month of requested termination?**

Reason for termination: *Check all that apply.*

☐ **End of Employment (voluntary)** ☐ **Reduction in Hours** ☐ **Divorce: Date of Decree** (must submit divorce papers)

☐ **End of Employment (involuntary)** ☐ **Death of Employee** ☐ **Entitlement to Medicare** ☐ **Eligible for Other Health Coverage**

☐ **Dependent Status Change (ex: dependent is 26 and no longer qualifies as a dependent)**

☐ **Other**

Voluntary Termination: If voluntary termination, employee (subscriber) must sign.

Employee (Subscriber) Signature: **Date (MM/DD/YYYY)**

Section IV: Signature of Group Administrator

In signing below, I represent that the statements on this form (or any attachment hereto) are true, complete, and correctly recorded to the best of my knowledge and belief.

Print Group Administrator Name	Group Administrator Signature (Required)	DOB