Office of Management and Enterprise Services
Employees Group Insurance Division
Insurance Termination Form

EMPLOYER INFORMATION

Group ID#:_____ Division ID#:_____ Group Name: _____

EMPLOYEE INFORMATION

SSN or Member ID # _____

Employee Name: _____ _____ _____

First Name Middle Initial Last Name

INSURANCE TERMINATION DATE

Please enter the last month of coverage for which premiums will be paid for this employee.
(This may or may not be the date the employee leaves employment.)

Month	Year

Note: EGID does not prorate premiums. Premiums must be paid in full month increments.

REASON FOR TERMINATION

FOR EGID USE ONLY

- ☐ Termination of Employment
- ☐ Death of Employee Date of Death: _____
- ☐ Transfer to Another EGID Participating Employer
  Name of the Receiving Employer (if known): _____
- ☐ Other (please specify): _____

Reminder: It is the Insurance Coordinator's responsibility to notify the employee of COBRA, Vesting, and Retirement rights.

CERTIFICATION SIGNATURE

I certify that this termination is in compliance with the provisions of the employer's Section 125 Plan or, if no 125 Plan is offered, is in compliance with allowed midyear coverage changes as defined by Title 26, Section 125, of the Internal Revenue Codes (as amended), and pertinent regulations.

Insurance Coordinator Signature: _____ Date:_____

(Must be signed by Insurance Coordinator to be valid)