Avera Health Plans

TO BE COMPLETED BY EMPLOYER

Employer Name: _____

Group Number: _____

Termination of Coverage Form

Employer is to complete this form to terminate coverage for an employee and/or the employee's dependents. See Page 2 for more information.

EMPLOYEE INFORMATION

Subscriber Name: _____ Subscriber Number or SSN: _____

Address: _____ City: _____

County: _____ State: _____ ZIP: _____ Home Phone: (_____) _____-_____

QUALIFYING EVENT (Continuation Coverage)

Coverage (check all that apply): ☐ Medical Plan ☐ Dental Plan ☐ Vision Plan

Coverage Effective Date: _____ Qualifying Event Date: _____ Last Day of Coverage: _____ COBRA Begin Date: _____

EMPLOYEE

☐ Termination of Employment
- ☐ Lay-off
- ☐ Medical Leave of Absence
- ☐ Non-Medical Leave of Absence
- ☐ Other, Explain: _____

☐ Reduction in Hours (Full-time to Part-time)

DEPENDENT

☐ Death of Covered Employee

☐ Employee's Entitlement to Medicare

Ø Did the employee term employment or have reduction in hours? ☐ Yes ☐ No

☐ Child's Loss of Dependent Status

☐ Divorce, please attach copy of divorce decree or ex-spouse's signature below.*

☐ Other, Explain: _____

List Dependents: _____

_____

VOLUNTARY TERMINATION OF SUBSCRIBER AND/OR DEPENDENT(S) COVERAGE

Coverage (check all that apply): ☐ Medical Plan ☐ Dental Plan ☐ Vision Plan

Last day of coverage: _____

☐ Termination of Subscriber Coverage ☐ Termination of Dependent(s) Coverage (List names below.)

List Dependent(s): _____

Reason (check one): ☐ Other Coverage ☐ Terminating Coverage Voluntarily (still employed) ☐ Other: _____

NOTE: Avera Health Plans ***requires*** the signed consent from the subscriber and dependent spouse* for any voluntary termination of coverage.

I understand that the termination date with Avera Health Plans will be the last day of the month in which termination was requested or the last day of the month in which this form is received by Avera Health Plans, whichever is later.

Employee Signature: _____ Date: _____

I, the undersigned, hereby give my informed consent to be terminated from dependent spouse coverage under Avera Health Plans.

***Spouse Signature**: _____ Date: _____

EMPLOYER INFORMATION The following must be completed by an authorized employer group representative.

Name/Completed By *(please print)*: _____ Phone: _____ Date: _____

Employer Signature: _____ Email: _____

Please fax completed form to (605) 322-4689 or mail to: Avera Health Plans, Enrollment Dept.
3816 S. Elmwood Ave., Suite 100
Sioux Falls, SD 57105-6538

If any questions, please call our Service Center at (605) 322-4545 or toll-free 1 (888) 322-2115, 8 a.m. to 5 p.m. CT, Monday through Friday.

Instructions for Completing the Termination of Coverage Form

Use this form to terminate coverage for an employee or an employee's dependents.

EMPLOYEE INFORMATION SECTION

Complete this section with the employee's information as requested.

QUALIFYING EVENT SECTION

To Be Completed by the Employer: Complete this section if the employee is terminating coverage or a dependent is terminating coverage *and* there is a qualifying event for continuation coverage. It is important that all requested fields are completed so that we can administer continuation coverage rights accordingly.

Coverage Effective Date: Enter the original effective date of coverage.

Qualifying Event Date: Enter the date on which the qualifying event occurred. For example, if the event is *Termination of Employment*, the qualifying event date would be the last day that the employee worked, although coverage may extend through the end of that month. The qualifying event date is required for the administration of continuation coverage.

Last Day of Coverage: Enter the date on which the employer-paid coverage ceases. For example, an employee may leave employment on Oct. 15 (the qualifying date) and be covered through the end of the month, Oct. 31. Therefore, Oct. 31, would be the last day of coverage.

COBRA Begin Date: This is the first day of the COBRA continuation period. In most cases, the COBRA begin date is the first day of the month following the date of the qualifying event. For example, the qualifying event date is Oct. 15. The last day of coverage would be Oct.31. Therefore, COBRA coverage begins Nov. 1.

Sometimes there may be contractual arrangements where an employee's coverage is paid for a period of time by the employer and this paid portion is not included in the COBRA continuation period.

VOLUNTARY TERMINATION OF SUBSCRIBER AND/OR DEPENDENT(S) COVERAGE SECTION

Employer Requirements: Complete this section if an employee or the employee's dependent(s) ***voluntarily*** requests to cancel their coverage. A voluntary cancellation of coverage does not constitute a qualifying event for continuation coverage. Check all applicable boxes and note date of cancellation.

Avera Health Plans must be notified in writing prior to the date to end coverage for any voluntary terminations. Cancellation will take place on the last day of the month in which the termination was requested or the last day of the month in which this Termination of Coverage Form was received by Avera Health Plans, whichever is later.

Employee Requirements: To voluntarily cancel coverage for the employee or the employee's dependents, the employee's signature is required.

Spouse's Signature Requirements: If the covered, dependent spouse requests to voluntarily cancel coverage, the signature of the spouse is required.

EMPLOYER INFORMATION SECTION

An authorized employer representative is required to sign and complete this section to authorize Avera Health Plans to process any termination of coverage request.

Avera Health Plans