

Termination Form

Please complete this form to terminate coverage for an employee and/or the employee's dependents.

Company Name		Customer #	
Employee Name – Last	First	Middle Initial	Social Security Number

Terminate coverage for:

Check one: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Only <input type="checkbox"/> Spouse Only	<input type="checkbox"/> Children Only <input type="checkbox"/> One Child Only, Provide Name: _____	Terminate coverage for (check all that apply): <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> STD	COBRA: <input type="checkbox"/> Offer COBRA <input type="checkbox"/> Term COBRA	Requested Term Date _____
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REASON FOR TERMINATION OF COVERAGE (check one):

<input type="checkbox"/> Employee terminated employment. Last day of full-time employment: _____	<input type="checkbox"/> Employee no longer eligible. Please explain:
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Employer Signature	Print Name	EMAIL ADDRESS*	Date
<input type="checkbox"/> Other coverage	<input type="checkbox"/> Death	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce
<input type="checkbox"/> Other: _____			

Photocopy if more forms are required

* Email addresses are for sending confirmations only and will not be used for any other purposes.

To submit this request for termination of coverage:**Mail to:**

BEST Life and Health Insurance Company
 Attn. Administration
 PO Box 19721
 Irvine, CA 92623

Email to: changes@bestlife.com

Fax to: Attn. Administration, 949.724.1603

PLEASE NOTE: Do not make adjustments on your bill for terminated employees or dependents. When termination of coverage is processed, the adjustment will appear on your next bill.