

Completed by:

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TERMINATION

PLEASE USE BLUE OR BLACK INK ONLY

Plan Use Only	
Rec: Medical	

TRM-09

- CONFIDENTIAL -

By submission of this form, the group certifies that, if any termination of coverage date supplied will result in a retroactive termination, such termination is in compliance with the Patient Protection and Affordable Care Act.

INSTRUCTIONS: Complete Section: 1 to terminate Employee/Elect Continuation Coverage

- 1 to terminate Employee and all Dependents/Elect Continuation Coverage for Employee and all Dependents
- 1 & 2 to terminate Employee/Elect Continuation Coverage for Some Dependents
- 2 to terminate Specific Dependents/Elect Continuation Coverage

If you purchased COBRA Administration from BlueCross BlueShield of Tennessee, do not complete this form. Instead, complete the COBRA Coverage Continuation Notice (CCN) online at bcbst.com. If Employee elects COBRA/State Continuation at a later date, fill out Employee Enrollment/Waiver Form.

	GROUP NAME		date, illi out Employee Emoliment		IIELD OF TN BILLING ASSOCIATE	
		G 11] BLULUKUSS BLULSI	IILLD OF THE BILLING ASSOCIATE	
120156	Tusculum	College				
Section 1 - Employee Termination						
EMPLOYEE LAST NAME	EMI	PLOYEE FIRST NAME	MI	IDENTIFICATION NO.		TERMINATION DATE OF COVERAGE [0 3] / [3 1] / [2 0 1 4]
COVERAGE TO TERMINATE: ME	EDICAL					
REASON: TERMINATION OF EM	IPLOYMENT 🚨	REDUCTION IN HOURS	NO LONGER ELIGIBLE EMPL	OYEE DEATH MEDIO	CARE ELIGIBLE OTHER	OPEN ENROLLMENT QUALIFYING EVENT DATE $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$
It is a crime to knowingly provide fall	lse, incomplete o	or misleading information to	an insurance company for the	purpose of defrauding the comp	any. Penalties include impris	onment, fines and denial of coverage.

Phone Number:

Section 2 - Spouse / Dependent(s) Termination							
EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME MI IDENTIFICATION NO.						
□ I WISH TO CHANGE TO SUBSCRIBER ONLY COVERAGE. APPLIES TO: □ MEDICAL [DO NOT LIST SPOUSE/DEPENDENT(S)]							
☐ I WISH TO TERMINATE ONLY THE SPOU							
DEPENDENT LAST NAME	DEPENDENT FIRST NAME MI DEPENDENT SOCIAL SECURITY NO. DATE OF BIRTH	TERMINATION DATE					
COVERAGE TO TERMINATE		03/31/2014					
☐ MEDICAL	REASON: NO LONGER ELIGIBLE DEPENDENT DEPENDENT DIVORCE ELIGIBLE DEPENDENT DEPENDENT OTHER OTHER	en Enrollment					
NEW ADDRESS FOR DEPENDENT							
DEPENDENT LAST NAME	DEPENDENT FIRST NAME MI DEPENDENT SOCIAL SECURITY NO. DATE OF BIRTH	TERMINATION DATE [0 3]/[3 1]/[2 0 1 4]					
COVERAGE TO TERMINATE	REASON: NO LONGER ELIGIBLE MEDICARE DEATH OF DEATH OF	0 3 7 3 1 7 2 0 1 1					
☐ MEDICAL		oen Enrollment					
NEW ADDRESS FOR DEPENDENT							
DEPENDENT LAST NAME	DEPENDENT FIRST NAME MI DEPENDENT SOCIAL SECURITY NO. DATE OF BIRTH	TERMINATION DATE					
		0 3 / 3 1 / 2 0 1 4					
COVERAGE TO TERMINATE MEDICAL	REASON: NO LONGER ELIGIBLE MEDICARE DEATH OF DEATH OF OTHER OTHER OTHER	oen Enrollment					
MEDICAL		ZOIT EMPORTMENT					
NEW ADDRESS FOR DEPENDENT							
DEPENDENT LAST NAME	DEPENDENT FIRST NAME MI DEPENDENT SOCIAL SECURITY NO. DATE OF BIRTH	TERMINATION DATE					
		0 3 / 3 1 / 2 0 1 4					
COVERAGE TO TERMINATE	REASON: NO LONGER ELIGIBLE MEDICARE DEATH OF DEATH OF OTHER OTHER OTHER	en Enrollment					
MEDICAL		en Emonnem					
NEW ADDRESS FOR DEPENDENT							