

1 Cameron Hill Circle Chattanooga, TN 37402-0001 bcbst.com

TERMINATION

PLEASE USE BLUE OR BLACK INK ONLY

Plan Use Only	
Rec:	

TRM-15

- 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

ii Employee elects COBRAState Continuation at a later date, fill out E	imployee Emoliment walver i of		
GROUP NO. GROUP NAME		BLUECROSS BLUESHIELD OF TN BILLING	ASSOCIATE
Section 1 - Employee Termination			
EMPLOYEE LAST NAME EMPLOYEE FIRST NAME	MI IDE	NTIFICATION NO.	TERMINATION DATE OF COVERAGE
COVERAGE TO TERMINATE: MEDICAL DENTAL VISION LIFE LIFE	HEALTH CARE FSA	EPENDENT CARE FSA	
REASON: TERMINATION OF EMPLOYMENT REDUCTION IN HOURS NO LON	GER ELIGIBLE EMPLOYEE	🗖 DEATH 🔲 MEDICARE ELIGIBLE 🔲	OTHER
STATE CONTINUATION OF COVERAGE (Groups under 20) MEDICAL DENTAL VISION COBRA COVERAGE (Groups of 20 or 10 medical Dental Denta	more) COBRA SU	BGROUP DEPARTMENT NO.	QUALIFYING EVENT DATE
EMPLOYEE LAST NAME EMPLOYEE FIRST NAME	MI IDE	NTIFICATION NO.	TERMINATION DATE OF COVERAGE
COVERAGE TO TERMINATE: MEDICAL DENTAL VISION LIFE LIFE	HEALTH CARE FSA	EPENDENT CARE FSA	
REASON: TERMINATION OF EMPLOYMENT TO REDUCTION IN HOURS TO NO LON	GER ELIGIBLE EMPLOYEE	⊒ DEATH □ MEDICARE ELICIBLE □	- OTHER
STATE CONTINUATION OF COVERAGE (Groups under 20)	COBRA SI	BGROUP DEPARTMENT NO.	QUALIFYING EVENT DATE
	VISION		
EMPLOYEE LAST NAME EMPLOYEE FIRST NAME	MI IDE	NTIFICATION NO.	TERMINATION DATE OF COVERAGE
CO VERAGE TO TERMINATE: MEDICAL DENTAL VISION LIFE 	HEALTH CARE FSA 🔲 E	EPENDENT CARE FSA	
REASON: TERMINATION OF EMPLOYMENT TO REDUCTION IN HOURS TO NO LON	GER ELIGIBLE EMPLOYEE	DEATH DEMEDICARE ELIGIBLE DE	- OTHER
STATE CONTINUATION OF COVERAGE (Groups under 20)	COBRA SI	BGROUP DEPARTMENT NO.	QUALIFYING EVENT DATE
	VISION		
EMPLOYEE LAST NAME EMPLOYEE FIRST NAME	MI IDE	NTIFICATION NO.	TERMINATION DATE OF COVERAGE
COVERAGE TO TERMINATE: MEDICAL DENTAL VISION LIFE LIFE	HEALTH CARE FSA 🔲 E	EPENDENT CARE FSA	
REASON: TERMINATION OF EMPLOYMENT TO REDUCTION IN HOURS ON LON	GER ELIGIBLE EMPLOYEE	☐ DEATH ☐ MEDICARE ELIGIBLE ☐	- OTHER
STATE CONTINUATION OF COVERAGE (Groups under 20) COBRA COVERAGE (Groups of 20 or 1)	more) COBRA SI	BGROUP DEPARTMENT NO.	QUALIFYING EVENT DATE
☐ MEDICAL ☐ DENTAL ☐ VISION ☐ MEDICAL ☐ DENTAL ☐	VISION		
It is a crime to knowingly provide false, incomplete or misleading information to an insurance	e company for the purpose	of defrauding the company. Penalties incl	ude imprisonment, fines and denial of coverage.
Completed by:	Phone Number:		Date: / /

Section 2 - Spouse / Dependent(s) Termination		
EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME MI IDENTIFICATION NO.	TERMINATION DATE OF COVERAGE
☐ I WISH TO CHANGE TO SUBSCRIBER O	ONLY COVERAGE. APPLIES TO: 🔲 MEDICAL 🔒 DENTAL 🔒 VISION [DO NOT LIST SPOUSE/DE	PENDENT(S)]
☐ I WISH TO TERMINATE ONLY THE SPOU	JSE/DEPENDENT(S) LISTED BELOW.	
DEPENDENT LAST NAME	DEPENDENT FIRST NAME MI DEPENDENT SSN/TIN DATE OF BIRTH	TERMINATION DATE
COVERAGE TO TERMINATE MEDICAL DENTAL VISION	REASON: NO LONGER ELIGIBLE DEATH OF DEA	
STATE CONTINUATION OF COVERAGE (Groups under MEDICAL DENTAL VISION	er 20) COBRA COVERAGE (Groups of 20 or more) MEDICAL DENTAL VISION COBRA SUBGROUP DEPARTMENT NO:	QUALIFYING EVENT DATE
NEW ADDRESS FOR DEPENDENT		
DEPENDENT LAST NAME	DEPENDENT FIRST NAME MI DEPENDENT SSN/TIN DATE OF BIRTH	TERMINATION DATE
COVERAGE TO TERMINATE MEDICAL — DENTAL — VISION	REASON: NO LONGER ELIGIBLE MEDICARE DEATH OF DEATH OF DEPENDENT DEPENDENT SUBSCRIBER OTHER	
STATE CONTINUATION OF COVERAGE (Groups under MEDICAL DENTAL VISION	er 20) COBRA COVERAGE (Groups of 20 or more) ☐ MEDICAL ☐ DENTAL ☐ VISION COBRA SUBGROUP DEPARTMENT NO.	QUALIFYING EVENT DATE
NEW ADDRESS FOR DEPENDENT		
EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME MI IDENTIFICATION NO:	TERMINATION DATE OF COVERAGE
EMPLOYEE LAST NAME		
☐ I-WISH TO CHANGE TO SUBSCRIBER O	ONLY COVERAGE: APPLIES TO: DEMEDICAL DENTAL	
	ONLY COVERAGE: APPLIES TO: DEMEDICAL DENTAL	
☐ I WISH TO CHANGE TO SUBSCRIBER O	DNLY COVERAGE: APPLIES TO: MEDICAL DENTAL DIVISION [DO NOT LIST SPOUSE/DEI USE/DEPENDENT (S) LISTED BELOW. DEPENDENT FIRST NAME MI DEPENDENT SSN/TIN DATE OF BIRTH REASON: NO LONGER ELIGIBLE MEDICARE DEATH OF DEATH OF DEPENDENT DEPENDENT DEPENDENT SUBSCRIBER OTHER	PENDENT(S)]
☐ I WISH TO CHANGE TO SUBSCRIBER OF DEPENDENT LAST NAME COVERAGE TO TERMINATE	DNLY COVERAGE: APPLIES TO: MEDICAL DENTAL VISION [DO NOT LIST SPOUSE/DEI USE/DEPENDENT(S) LISTED BELOW. DEPENDENT FIRST NAME MI DEPENDENT SSN/TIN DATE OF BIRTH REASON: NO LONGER ELIGIBLE MEDICARE DEATH OF DEATH OF DEATH OF DEPENDENT DEPENDENT SUBSCRIBER OTHER COPRA SUBCROLUP DEPARTMENT NO.	PENDENT(S)]
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☐ I WISH TO CHANGE TO SUBSCRIBER OF THE SPOUND IN WISH TO TERMINATE ONLY THE SPOUND IN WISH TO TERMINATE ONLY THE SPOUND IN WISH TO TERMINATE OF COVERAGE TO TERMINATE OF COVERAGE (Groups under the continuation of Coverage (Groups under the coverage (Gro	DEPENDENT FIRST NAME DEPENDENT FIRST NAME DEPENDENT OF BIRTH DEPENDENT SSN/TIN DEPENDENT SSN/TIN DEPENDENT SSN/TIN DEPENDENT SSN/TIN DATE OF BIRTH DEPENDENT SSN/TIN DATE OF BIRTH DEPENDENT SSN/TIN DATE OF BIRTH DEPENDENT OF BIRTH DEPENDENT OF BIRTH REASON: NO LONGER ELIGIBLE DIVORCE DEATH OF DEATH	TERMINATION DATE QUALIFYING EVENT DATE TERMINATION DATE TERMINATION DATE
□ I WISH TO CHANGE TO SUBSCRIBER OF DEPENDENT LAST NAME □ MEDICAL □ DENTAL □ VISION STATE CONTINUATION OF COVERAGE (Groups under DEPENDENT LAST NAME) □ MEDICAL □ DENTAL □ VISION NEW ADDRESS FOR DEPENDENT □ DEPENDENT LAST NAME □ COVERAGE TO TERMINATE	DEPENDENT FIRST NAME DEPENDENT FIRST NAME MI DEPENDENT SSN/TIN DEPENDENT SSN/TIN DEPENDENT DEPENDENT DEP	PENDENT(S)] TERMINATION DATE