Allied

Call/Fax:
Tel: 877-411-1015
FAX: 312-416-2860
E-mail: usbenefits.membertermination@alliedbenefit.com

Please Complete and return via FAX or E-mail

FORM INSTRUCTIONS

Please complete the form and submit to Allied within 30 days of a member coverage termination.

EMPLOYER INFORMATION

Group Name:	
Group Number:	

EMPLOYEE INFORMATION

Employee Name: _____ (Last) _____ (First) _____ (Middle Initial)

Employee Social Security Number: _____

Employee Date of Birth: ____ (MM) ____ (DD) ____ (CCYY)

Employee Address | **City** | **State** | **Zip Code**

TERMINATION INFORMATION

Date of Insurance Term:

Coverage Termination Date (last day covered under the plan): _____ _____ _____
MM DD CCYY

*Coverage termination date ends on the last day of month

☐**Check if coverage should terminate back to the coverage effective date (i.e. employee/dependents should have never been under the plan)**

Qualifying Event Reason (choose one)

☐Employee's Termination or Employee's Layoff	☐Employee's Reduction in Hours	☐Employee's Death	☐Spouse's Divorce or Legal Separation from Employee
☐Dependent Child Ceasing to Qualify Under the Plan	☐Medicare Entitlement	☐Dropping Coverage (specify on form which member is to be termed)	☐Terminate back to coverage effective date (no coverage under the plan)

If a Termination of Employment was the Qualifying Event, please indicate whether the Termination was Voluntary or Involuntary:

☐Involuntary ☐Voluntary

EMPLOYEE/DEPENDENTS TO BE TERMINATED

Employee Name	Relationship	Gender	Birth Date MM/DD/CCYY	Social Security Number	Effective Date MM/DD/CCYY	Coverage Type
	Employee	☐M ☐F				☐Dental
Dependent Name(s)		☐M ☐F				
	☐Spouse ☐Child	☐M ☐F				☐Dental
	☐Child	☐M ☐F				☐Dental
	☐Child	☐M ☐F				☐Dental
	☐Child	☐M ☐F				☐Dental

AUTHORIZATION

I certify that the above information is accurate. *If applicable*, I authorize Allied Benefit Systems, Inc. to notify those individuals whom I have certified of their COBRA rights and creditable coverage.

_____ _____

For Office Use Only:	Date Processed: / /20	By:_____