

801 Pine Street Chattanooga, TN 37402-2555 www.bcbst.com

TERMINATION

PLEASE USE BLUE OR BLACK INK ONLY

Plan Use Only	
Rec:	TRM

IF YOU PURCHASED COBRA ADMINISTRATION FROM BLUECROSS BLUESHIELD OF TENNESSEE, DO NOT COMPLETE THIS FORM. INSTEAD, COMPLETE THE COBRA COVERAGE CONTINUATION NOTICE (GB-108). **GROUP NAME** GROUP NO. BLUECROSS BLUESHIELD OF TN BILLING ASSOCIATE 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 Employee wants COBRA / State Continuation at a later date, fill out Employee Enrollment / Waiver Form. Section 1 - Employee Termination MI **IDENTIFICATION NO:** TERMINATION DATE OF COVERAGE EMPLOYEE FIRST NAME EMPLOYEE LAST NAME **COVERAGE TO TERMINATE TERMINATION** REDUCTION REASON: ☐ MEDICARE ELIGIBLE П OF EMPLOYMENT IN HOURS □ NO LONGER ELIGIBLE EMPLOYEE DEATH ☐ OTHER ☐ MEDICAL ☐ DENTAL ☐ LIFE QUALIFYING EVENT DATE: COBRA SUBGROUP DEPARTMENT NO: STATE CONTINUATION OF COVERAGE (Grps under 20) COBRA COVERAGE ELECTED M M D ☐ MEDICAL □ DENTAL □ MEDICAL □ DENTAL TERMINATION DATE OF COVERAGE MI EMPLOYEE LAST NAME EMPLOYEE FIRST NAME **IDENTIFICATION NO:** COVERAGE TO TERMINATE **TERMINATION** REDUCTION REASON: OF EMPLOYMENT □ NO LONGER ELIGIBLE EMPLOYEE MEDICARE ELIGIBLE ☐ OTHER IN HOURS DEATH ☐ MEDICAL ☐ DENTAL QUALIFYING EVENT DATE: COBRA SUBGROUP DEPARTMENT NO: STATE CONTINUATION OF COVERAGE (Grps under 20) COBRA COVERAGE ELECTED M M D D ☐ MEDICAL □ DENTAL □ MEDICAL □ DENTAL MI IDENTIFICATION NO TERMINATION DATE OF COVERAGE **EMPLOYEE LAST NAME** EMPLOYEE FIRST NAME COVERAGE TO TERMINATE **TERMINATION** REDUCTION ☐ MEDICARE ELIGIBLE □ OTHER REASON: OF EMPLOYMENT IN HOURS □ NO LONGER ELIGIBLE EMPLOYEE DEATH ☐ MEDICAL ☐ DENTAL ☐ LIFE QUALIFYING EVENT DATE: DEPARTMENT NO: COBRA SUBGROUP STATE CONTINUATION OF COVERAGE (Grps under 20) COBRA COVERAGE ELECTED M M D D Y ☐ MEDICAL ☐ DENTAL ☐ MEDICAL □ DENTAL MI **IDENTIFICATION NO** TERMINATION DATE OF COVERAGE EMPLOYEE LAST NAME EMPLOYEE FIRST NAME **TERMINATION** REDUCTION COVERAGE TO TERMINATE REASON: OF EMPLOYMENT ☐ IN HOURS □ NO LONGER ELIGIBLE EMPLOYEE ☐ DEATH ☐ MEDICARE ELIGIBLE □ OTHER ☐ MEDICAL ☐ DENTAL ☐ LIFE QUALIFYING EVENT DATE: STATE CONTINUATION OF COVERAGE (Grps under 20) COBRA SUBGROUP DEPARTMENT NO: $\mathsf{M} \ \mathsf{M} \ \mathsf{D} \ \mathsf{D} \ \mathsf{Y}$ COBRA COVERAGE ELECTED ☐ MEDICAL ☐ DENTAL □ MEDICAL □ DENTAL It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage. M D D Completed by: Phone Number: Date:

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

Section 2 – Spouse / Dependent (s) Termination
EMPLOYEE LAST NAME EMPLOYEE FIRST NAME MI IDENTIFICATION NO: TERMINATION DATE OF COVERAGE
☐ I WISH TO CHANGE TO INDIVIDUAL COVERAGE. APPLIES TO: ☐ MEDICAL ☐ DENTAL (DO NOT LIST SPOUSE / DEPENDENT(S))
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