QualChoice® HEALTH INSURANCE

Termination Form

Please use this form to **terminate** a subscriber or dependent's eligibility status. The form **must** be signed by Group Administrator. To add, change or update a member's status, please submit a *Change Form*. Mail or fax this form to address below or email *to QCA_Enrollment@qualchoice.com.*

Section I: Employee (Subscriber) Information

Employee (Subscriber) Legal Name *(Last, First, MI)*	QualChoice ID No. or Social Security No.	Group/Plan Sponsor Name

Section II: Terminating Coverage

This is to confirm that I elect to terminate participation in my employer's group health plan as indicated below. Please check all that apply.

Type of coverage being terminated	☐ **Medical**	☐ **Dental**	☐ **Vision**	☐ **Life Insurance**
Who is coverage being terminated for? *If **Self** is checked, spouse and dependent(s) will also be terminated.*	☐ Self (Subscriber) ☐ Spouse ☐ Dependent(s)	☐ Self (Subscriber) ☐ Spouse ☐ Dependent(s)	☐ Self (Subscriber) ☐ Spouse ☐ Dependent(s)	☐ Self (Subscriber) ☐ Spouse ☐ Dependent(s)

Legal name of employee (subscriber) to be terminated (Last, First):_____

Subscriber's last date of employment*_____

Termination date is last day of the month of last date of employment.

Legal name of spouse to be terminated (Last, First):_____

For termination date, give **last day of the month** of termination*:_____

Legal name of dependent to be terminated (Last, First):_____

For termination date, give **last day of the month** of termination*:_____ Attach extra page if needed for additional dependents.

**Example: If last date of employment is June 5 or termination is requested on June 5, then subscriber, spouse, or dependent termination date will be June 30.*

Section III: Termination Information

Please submit employee and/or dependent terminations as they occur.

Under the Affordable Care Act, a cancellation or discontinuance of health coverage that has a retroactive effect is not allowed in the absence of fraud, intentional misrepresentation of a material fact, or failure to pay required contributions timely. Even if it was an administrative error to allow an individual to remain on the plan, if that individual was allowed to continue to pay premiums, it is unlikely that coverage can be canceled retroactively.

☐ **Yes** ☐ **No** If requested termination date is more than 30 days from the date this form was signed; did the employee (subscriber) pay any premium for health benefits coverage **after** the last day of the month of requested termination?

Reason for Termination: *Check all that apply. If termination is voluntary, employee (subscriber) signature is required below.*

☐ Left employment ☐ Retirement ☐ Death ☐ Eligible for Other Health Coverage ☐ Divorce: Date of Decree _____
Must submit divorce papers.

☐ Dependent Status Change (Example: Dependent is age 26 and no longer qualifies as a dependent)

☐ Other _____

1. If employee (subscriber) elected COBRA, please submit a *Change Form.* **NOTE:** Refer to Federal COBRA Guidelines (www.dol.gov) regarding federal COBRA eligibility, rules and regulations.
2. If employee (subscriber) elected 'State Continuation', please attach **Arkansas State Group Continuation Coverage Election Form.**† **NOTE:** The law allows a former employee or former dependent to extend their group health insurance coverage for up to 120 days. In order to be eligible for this option, the former employee or dependent must have been continuously covered under the group health insurance policy for at least three consecutive months prior to employment termination or change in dependency status and must make the election by notifying the insurer no later than ten days after employment termination or change in dependency status.

Voluntary Termination: If voluntary termination, employee (subscriber) must sign.

Employee (Subscriber) Signature	Date (MM/DD/YYYY)
X	

Section IV: Signature of Group Administrator

In signing below, I represent that the statements on this form (or any attachment hereto) are true, complete and correctly recorded to the best of my knowledge and belief.

Print Group Administrator Name	Group Administrator Signature (Required)	Date (MM/DD/YYYY)
	X	

†Form available at QualChoice.com, select Employers. Or call us to request a copy free of charge.