



Employee Termination of Insurance Form

North Coast Builders Exchange Insurance Trust

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To add or delete a dependent, a Insurance Change Request Form must be submitted.

To cancel coverage (health, dental, vision and/or life) for an active employee, a Declination Form must be submitted.

EMPLOYEE TERMINATION

This form is to notify the North Coast Builders Exchange Insurance Trust that the employee listed below has experienced a "Qualifying Event" and is no longer eligible for plan coverage.

Notification must be made within 30 days of the event.

Firm #	Company Name	Date		
** IMPORTANT **				
Due to Federal COBRA/Cal-COBRA Regulations, please ensure that you provide the last known address for the employee and all enrolled dependents below. Your Human Resources or Payroll Department may have the most current information.				
Employee Name		Social Security #		
Street Address		City	State	Zip
ADDRESS OF ANY DEPENDENT IF DIFFERENT THAN EMPLOYEE'S ADDRESS				
Dependent Name				
Dependent Address *		City	State	Zip

* If a Qualified Medical Support Order is enforce, please supply name and address of Support Agency.

QUALIFYING EVENT

EMPLOYMENT TERMINATION EFFECTIVE DATE: _____ (The 1st day of unemployment)

COVERAGE TERMINATION DATE: _____ (The 1st day of the month on or following the qualifying event)

Qualifying Event

- Voluntary termination of employment** (resignation, retirement)
- Involuntary termination of employment** (layoff, employee terminated)
- Termination of employment for Gross Misconduct** (no COBRA will be offered, Legal advise is strongly suggested)
- Employee's Medicare Entitlement**
- Death of Employee**
- Reduction in work hours**
- Military leave**
- Leave of absence**
- Other:**

EMPLOYER / AUTHORIZED SIGNATURE

DATE

Print Name

Job Title