Request to Terminate COBRA Coverage

Today's Date:_____

Participant's Name:_____

Participant's Social Security Number:_____

Client:_____

I would like to terminate the benefits selected below effective:_____
(Please note: Indicate last date of COBRA Coverage.)

Please indicate which benefits you would like to terminate by marking "DROP" in the boxes below.

	NAME	SIGNATURE REQUIRED IF OVER AGE 18	MEDICAL	DENTAL	VISION	EAP	FSA	OTHER (Please list)
PARTICIPANT			☐ Drop	☐ Drop	☐ Drop	☐ Drop	☐ Drop	☐ Drop
DEPENDENT 1			☐ Drop	☐ Drop	☐ Drop	☐ Drop	☐ Drop	☐ Drop
DEPENDENT 2			☐ Drop	☐ Drop	☐ Drop	☐ Drop	☐ Drop	☐ Drop
DEPENDENT 3			☐ Drop	☐ Drop	☐ Drop	☐ Drop	☐ Drop	☐ Drop
DEPENDENT 4			☐ Drop	☐ Drop	☐ Drop	☐ Drop	☐ Drop	☐ Drop

Reason for terminating benefits:

_____

_____

_____ _____

(Participant Signature) (Phone Number)

Please return to: benefitexpress
P.O. Box 2798
Omaha, NE. 68103
Phone: (877) 837-5017
Fax: (253) 793-3766