DAVEVIC

Benefit Consultants, Inc.

Employee Termination of Insurance Form

Please complete the below form for COBRA mailing requirements!
Email to: *group@davevic.com* OR Fax to: *724.458.1702*

ALL BELOW FIELDS ARE REQUIRED

Employer Name		**Date Coverage Terminates**	
Employee Name		**Social Security #**	
Date of Birth		**Date of Hire**	
Street Address		**City, State, Zip**	
Telephone #			

Termination of Insurance Coverage to be completed by: ☐ Davevic Benefit Consultants ☐ Employer

COBRA Notice of Qualifying Event

Date of Change

☐ Voluntary Termination ☐ Involuntary Termination

	Termination
	Hours reduced
	Date of Divorce
	Loss of Dependent Status
	Employee's Death
	Medicare Enrollment

If the Qualified Beneficiary is not the Employee, please complete this section:

Name	
Street Address	
City, State, Zip	

Form Completed By:_____

Enrollments

	Carrier & Plan Name	Group #	Level of Coverage**
Medical			
Dental			
Vision			
Life			
Long-Term Disability			
Short-Term Disability			
Flexible Spending Account		Last Payroll Contribution Date:	
Health Savings Account		Last Payroll Contribution Date:	

*A blank space indicates no enrollment. ** i.e. Employee Only, EE + Spouse, EE+Child(ren), Family

Enrolled Dependent(s)

	Name	Social Security #	Date of Birth
Spouse			
Child			
Child			
Child			
Child			