

ADA/COBRA ADMINISTRATION TERMINATION REQUEST FORM

Note: If terminating BCN coverage, a BCN termination form must accompany this document.

Dealership Name _____ Phone _____

Insurance Carrier	Group Number	Premium: at Termination	Single Person Rate
Health _____	_____	\$ _____/month	\$ _____/month
Prescr _____	_____	\$ _____/month	\$ _____/month
Dental _____	_____	\$ _____/month	\$ _____/month
Vision _____	_____	\$ _____/month	\$ _____/month
Other _____	_____	\$ _____/month	\$ _____/month

Employee Name _____
 Last Name _____ First Name _____ MI _____

Address _____
 Street _____ P.O. Box/Apt. # _____
 City _____ State _____ Zip Code _____ Phone (____) _____ - _____
 _____/____/____ Date of Birth _____ - _____ Social Security Number _____/____/____ Hire Date

COBRA Qualifying Event

- Voluntary Termination
- Involuntary Termination
- Layoff
- Reduced Hours
- Retirement
- Medicare Entitlement
- Death
- Divorce/Separation
- Ineligible Dependent
- FMLA Exhaustion
- Leave of Absence
- Other _____

Qualifying Event Occurred _____/____/____ Loss of Coverage Date _____/____/____

Has this employee or any qualified dependent been determined disabled by the Social Security Administration? Yes No

Dependents covered at Qualifying Event *(If more than four dependents, use back of form and check here)*

Name	Relationship (circle one)	Date of Birth	Social Security Number
_____	(Husband/Wife/Son/Daughter)	____/____/____	____ - ____ - ____
_____	(Husband/Wife/Son/Daughter)	____/____/____	____ - ____ - ____
_____	(Husband/Wife/Son/Daughter)	____/____/____	____ - ____ - ____
_____	(Husband/Wife/Son/Daughter)	____/____/____	____ - ____ - ____

Spouse address (if different than employee's)

Address _____
 Street _____ P.O. Box/Apt. # _____
 City _____ State _____ Zip Code _____ Phone (____) _____ - _____

Authorized Signature (of dealership representative) _____ Title _____ Date _____/____/____