of Tennessee

801 Pine Street
Chattanooga, TN 37402-2555
bcbst.com

- CONFIDENTIAL -

TERMINATION

PLEASE USE BLUE OR BLACK INK ONLY

Plan Use Only
Rec:_____

TRM-08

IF YOU PURCHASED COBRA ADMINISTRATION FROM BLUECROSS BLUESHIELD OF TENNESSEE, DO NOT COMPLETE THIS FORM. INSTEAD, COMPLETE THE COBRA COVERAGE CONTINUATION NOTICE (GB-108).

GROUP NO. | GROUP NAME | BLUECROSS BLUESHIELD OF TN BILLING ASSOCIATE

INSTRUCTIONS: Complete Section: 1 to terminate Employee / Elect Continuation Coverage
1 to terminate Employee and all Dependents / Elect Continuation Coverage for Employee and All Dependents
1 & 2 to terminate Employee / Elect Continuation Coverage for Some Dependents
2 to terminate Specific Dependents / Elect Continuation Coverage
If Employee wants COBRA / State Continuation at a later date, fill out Employee Enrollment / Waiver Form.

Section 1 - Employee Termination

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO | TERMINATION DATE OF COVERAGE (M M D D Y Y Y Y)

COVERAGE TO TERMINATE: ❑ MEDICAL ❑ DENTAL ❑ LIFE ❑ HEALTH CARE FSA ❑ DEPENDENT CARE FSA

REASON: ❑ TERMINATION OF EMPLOYMENT ❑ REDUCTION IN HOURS ❑ NO LONGER ELIGIBLE EMPLOYEE ❑ DEATH ❑ MEDICARE ELIGIBLE ❑ OTHER

STATE CONTINUATION OF COVERAGE (Grps under 20) ❑ MEDICAL ❑ DENTAL | COBRA COVERAGE ELECTED ❑ MEDICAL ❑ DENTAL | COBRA SUBGROUP | DEPARTMENT NO | QUALIFYING EVENT DATE (M M D D Y Y Y Y)

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO | TERMINATION DATE OF COVERAGE (M M D D Y Y Y Y)

COVERAGE TO TERMINATE: ❑ MEDICAL ❑ DENTAL ❑ LIFE ❑ HEALTH CARE FSA ❑ DEPENDENT CARE FSA

REASON: ❑ TERMINATION OF EMPLOYMENT ❑ REDUCTION IN HOURS ❑ NO LONGER ELIGIBLE EMPLOYEE ❑ DEATH ❑ MEDICARE ELIGIBLE ❑ OTHER

STATE CONTINUATION OF COVERAGE (Grps under 20) ❑ MEDICAL ❑ DENTAL | COBRA COVERAGE ELECTED ❑ MEDICAL ❑ DENTAL | COBRA SUBGROUP | DEPARTMENT NO | QUALIFYING EVENT DATE (M M D D Y Y Y Y)

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO | TERMINATION DATE OF COVERAGE (M M D D Y Y Y Y)

COVERAGE TO TERMINATE: ❑ MEDICAL ❑ DENTAL ❑ LIFE ❑ HEALTH CARE FSA ❑ DEPENDENT CARE FSA

REASON: ❑ TERMINATION OF EMPLOYMENT ❑ REDUCTION IN HOURS ❑ NO LONGER ELIGIBLE EMPLOYEE ❑ DEATH ❑ MEDICARE ELIGIBLE ❑ OTHER

STATE CONTINUATION OF COVERAGE (Grps under 20) ❑ MEDICAL ❑ DENTAL | COBRA COVERAGE ELECTED ❑ MEDICAL ❑ DENTAL | COBRA SUBGROUP | DEPARTMENT NO | QUALIFYING EVENT DATE (M M D D Y Y Y Y)

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO | TERMINATION DATE OF COVERAGE (M M D D Y Y Y Y)

COVERAGE TO TERMINATE: ❑ MEDICAL ❑ DENTAL ❑ LIFE ❑ HEALTH CARE FSA ❑ DEPENDENT CARE FSA

REASON: ❑ TERMINATION OF EMPLOYMENT ❑ REDUCTION IN HOURS ❑ NO LONGER ELIGIBLE EMPLOYEE ❑ DEATH ❑ MEDICARE ELIGIBLE ❑ OTHER

STATE CONTINUATION OF COVERAGE (Grps under 20) ❑ MEDICAL ❑ DENTAL | COBRA COVERAGE ELECTED ❑ MEDICAL ❑ DENTAL | COBRA SUBGROUP | DEPARTMENT NO | QUALIFYING EVENT DATE (M M D D Y Y Y Y)

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Completed by: | Phone Number: | Date: (M M D D Y Y Y Y)

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

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Section 2 - Spouse / Dependent(s) Termination

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO | TERMINATION DATE OF COVERAGE (M M D D Y Y Y Y)

❑ I WISH TO CHANGE TO INDIVIDUAL COVERAGE. APPLIES TO: ❑ MEDICAL ❑ DENTAL [DO NOT LIST SPOUSE / DEPENDENT(S)]

❑ I WISH TO TERMINATE ONLY THE SPOUSE / DEPENDENT(S) LISTED BELOW.

DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | DEPENDENT SOCIAL SECURITY NO | DATE OF BIRTH (M M D D Y Y Y Y) | TERMINATION DATE (M M D D Y Y Y Y)

COVERAGE TO TERMINATE
❑ MEDICAL ❑ DENTAL

REASON: ❑ NO LONGER ELIGIBLE DEPENDENT ❑ DIVORCE ❑ MEDICARE ELIGIBLE ❑ DEATH OF DEPENDENT ❑ DEATH OF SUBSCRIBER OTHER

STATE CONTINUATION OF COVERAGE (Grps under 20)
❑ MEDICAL ❑ DENTAL

COBRA COVERAGE ELECTED
❑ MEDICAL ❑ DENTAL

COBRA SUBGROUP | DEPARTMENT NO | QUALIFYING EVENT DATE (M M D D Y Y Y Y)

NEW ADDRESS FOR DEPENDENT

DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | DEPENDENT SOCIAL SECURITY NO | DATE OF BIRTH (M M D D Y Y Y Y) | TERMINATION DATE (M M D D Y Y Y Y)

COVERAGE TO TERMINATE
❑ MEDICAL ❑ DENTAL

REASON: ❑ NO LONGER ELIGIBLE DEPENDENT ❑ DIVORCE ❑ MEDICARE ELIGIBLE ❑ DEATH OF DEPENDENT ❑ DEATH OF SUBSCRIBER OTHER

STATE CONTINUATION OF COVERAGE (Grps under 20)
❑ MEDICAL ❑ DENTAL

COBRA COVERAGE ELECTED
❑ MEDICAL ❑ DENTAL

COBRA SUBGROUP | DEPARTMENT NO | QUALIFYING EVENT DATE (M M D D Y Y Y Y)

NEW ADDRESS FOR DEPENDENT

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO | TERMINATION DATE OF COVERAGE (M M D D Y Y Y Y)

❑ I WISH TO CHANGE TO INDIVIDUAL COVERAGE. APPLIES TO: ❑ MEDICAL ❑ DENTAL [DO NOT LIST SPOUSE / DEPENDENT(S)]

❑ I WISH TO TERMINATE ONLY THE SPOUSE / DEPENDENT(S) LISTED BELOW.

DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | DEPENDENT SOCIAL SECURITY NO | DATE OF BIRTH (M M D D Y Y Y Y) | TERMINATION DATE (M M D D Y Y Y Y)

COVERAGE TO TERMINATE
❑ MEDICAL ❑ DENTAL

REASON: ❑ NO LONGER ELIGIBLE DEPENDENT ❑ DIVORCE ❑ MEDICARE ELIGIBLE ❑ DEATH OF DEPENDENT ❑ DEATH OF SUBSCRIBER OTHER

STATE CONTINUATION OF COVERAGE (Grps under 20)
❑ MEDICAL ❑ DENTAL

COBRA COVERAGE ELECTED
❑ MEDICAL ❑ DENTAL

COBRA SUBGROUP | DEPARTMENT NO | QUALIFYING EVENT DATE (M M D D Y Y Y Y)

NEW ADDRESS FOR DEPENDENT

DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | DEPENDENT SOCIAL SECURITY NO | DATE OF BIRTH (M M D D Y Y Y Y) | TERMINATION DATE (M M D D Y Y Y Y)

COVERAGE TO TERMINATE
❑ MEDICAL ❑ DENTAL

REASON: ❑ NO LONGER ELIGIBLE DEPENDENT ❑ DIVORCE ❑ MEDICARE ELIGIBLE ❑ DEATH OF DEPENDENT ❑ DEATH OF SUBSCRIBER OTHER

STATE CONTINUATION OF COVERAGE (Grps under 20)
❑ MEDICAL ❑ DENTAL

COBRA COVERAGE ELECTED
❑ MEDICAL ❑ DENTAL

COBRA SUBGROUP | DEPARTMENT NO | QUALIFYING EVENT DATE (M M D D Y Y Y Y)

NEW ADDRESS FOR DEPENDENT