of Tennessee

1 Cameron Hill Circle
Chattanooga, TN 37402-0001
bcbst.com

- CONFIDENTIAL -

TERMINATION

PLEASE USE BLUE OR BLACK INK ONLY

Plan Use Only
Rec:_______________

TRM-15

By submission of this form, the group certifies that, if any termination of coverage date supplied will result in a retroactive termination, such termination is in compliance with the Patient Protection and Affordable Care Act.

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 you purchased COBRA Administration from BlueCross BlueShield of Tennessee, do not complete this form. Instead, complete the COBRA Coverage Continuation Notice (CCN) online at bcbst.com.
If Employee elects COBRA/State Continuation at a later date, fill out Employee Enrollment/Waiver Form.

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

Section 1 - Employee Termination

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO. | TERMINATION DATE OF COVERAGE __ / __ / ____

COVERAGE TO TERMINATE: ❑ MEDICAL ❑ DENTAL ❑ VISION ❑ 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 (Groups under 20) ❑ MEDICAL ❑ DENTAL ❑ VISION | COBRA COVERAGE (Groups of 20 or more) ❑ MEDICAL ❑ DENTAL ❑ VISION | COBRA SUBGROUP | DEPARTMENT NO. | QUALIFYING EVENT DATE __ / __ / ____

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO. | TERMINATION DATE OF COVERAGE __ / __ / ____

COVERAGE TO TERMINATE: ❑ MEDICAL ❑ DENTAL ❑ VISION ❑ 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 (Groups under 20) ❑ MEDICAL ❑ DENTAL ❑ VISION | COBRA COVERAGE (Groups of 20 or more) ❑ MEDICAL ❑ DENTAL ❑ VISION | COBRA SUBGROUP | DEPARTMENT NO. | QUALIFYING EVENT DATE __ / __ / ____

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO. | TERMINATION DATE OF COVERAGE __ / __ / ____

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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: __ / __ / ____

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

Section 2 - Spouse / Dependent(s) Termination

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO. | TERMINATION DATE OF COVERAGE

❑ I WISH TO CHANGE TO SUBSCRIBER ONLY COVERAGE. APPLIES TO: ❑ MEDICAL ❑ DENTAL ❑ VISION [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 SSN/TIN | DATE OF BIRTH | TERMINATION DATE

COVERAGE TO TERMINATE
❑ MEDICAL ❑ DENTAL ❑ VISION

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

STATE CONTINUATION OF COVERAGE (Groups under 20)
❑ MEDICAL ❑ DENTAL ❑ VISION

COBRA COVERAGE (Groups of 20 or more)
❑ MEDICAL ❑ DENTAL ❑ VISION

COBRA SUBGROUP | DEPARTMENT NO. | QUALIFYING EVENT DATE

NEW ADDRESS FOR DEPENDENT

DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | DEPENDENT SSN/TIN | DATE OF BIRTH | TERMINATION DATE

COVERAGE TO TERMINATE
❑ MEDICAL ❑ DENTAL ❑ VISION

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

STATE CONTINUATION OF COVERAGE (Groups under 20)
❑ MEDICAL ❑ DENTAL ❑ VISION

COBRA COVERAGE (Groups of 20 or more)
❑ MEDICAL ❑ DENTAL ❑ VISION

COBRA SUBGROUP | DEPARTMENT NO. | QUALIFYING EVENT DATE

NEW ADDRESS FOR DEPENDENT

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO. | TERMINATION DATE OF COVERAGE

❑ I WISH TO CHANGE TO SUBSCRIBER ONLY COVERAGE. APPLIES TO: ❑ MEDICAL ❑ DENTAL ❑ VISION [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 SSN/TIN | DATE OF BIRTH | TERMINATION DATE

COVERAGE TO TERMINATE
❑ MEDICAL ❑ DENTAL ❑ VISION

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

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❑ MEDICAL ❑ DENTAL ❑ VISION

COBRA COVERAGE (Groups of 20 or more)
❑ MEDICAL ❑ DENTAL ❑ VISION

COBRA SUBGROUP | DEPARTMENT NO. | QUALIFYING EVENT DATE

NEW ADDRESS FOR DEPENDENT

DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | DEPENDENT SSN/TIN | DATE OF BIRTH | TERMINATION DATE

COVERAGE TO TERMINATE
❑ MEDICAL ❑ DENTAL ❑ VISION

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

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