



# TERMINATION AND COBRA COVERAGE CONTINUATION REQUEST

**Instructions:** Complete this form only for coverage terminations related to employment. Complete the COBRA-QUALIFIED BENEFICIARY COVERAGE CONTINUATION NOTIFICATION REQUEST only for events not related to employment (e.g. dependents ineligible for coverage). Forms must be received at the League office by the 21<sup>st</sup> of the month. If received after the 21<sup>st</sup>, this information will appear on a subsequent premium statement. COBRA notifications are mailed to qualified beneficiaries every Friday.

Company Name	Authorized Signature <span style="float: right;">Date</span>
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**Please Print or Type**

Employee Last Name	Employee First Name	M.I.	Social Security Number	Check if Director <input type="checkbox"/>	
Street Address	City	State	Zip Code	Hire Date	Date of Birth

To cancel coverage, check the appropriate boxes and complete Reason for Coverage Termination.

New Jersey League Administered Programs			Non-New Jersey League Administered Programs					
Coverage Type	✓	Effective Date	Coverage Type	✓	Carrier	Effective Date	Contract Type*	
Healthcare	<input type="checkbox"/>	_____	Healthcare	<input type="checkbox"/>	_____	_____	_____	
Dental	<input type="checkbox"/>	_____	Dental	<input type="checkbox"/>	_____	_____	_____	
Vision	<input type="checkbox"/>	_____	Vision	<input type="checkbox"/>	_____	_____	_____	
Life	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	_____	_____	_____	
AD&D	<input type="checkbox"/>	_____	Does this employee participate in a flexible spending plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			* Contract Types		
Long Term Disability	<input type="checkbox"/>	_____	If so, the balance remaining is \$ _____			Employee Only	= S	
Voluntary Accident	<input type="checkbox"/>	_____					Parent/Child	= PC
Group Voluntary Life	<input type="checkbox"/>	_____					Employee/Spouse	= HW
							Family	= F

Reason for Termination of Coverage
✓ Please check one.
<input type="checkbox"/> Termination of employment on _____. (Coverage will be canceled on the last day of the month of termination.) Is there a severance agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No. If "yes", benefits should be extended until _____.
<input type="checkbox"/> Enrollment in outside healthcare coverage effective _____. Carrier: _____.
<input type="checkbox"/> Voluntary Withdrawal. Employee contributions discontinued on _____.
<input type="checkbox"/> Reduction of hours of employment on _____.
<input type="checkbox"/> Termination of benefits due to disability. Please check if disabled under Social Security. <input type="checkbox"/>
<input type="checkbox"/> Discontinuance of benefits due to Federal Family and Medical Leave.

**COBRA Coverage Terms for this form**

**18 Months**

- \* Reduction in work hours
- \* Termination of Employment

**29 Months**

- \* Social Security Disability