Termination Form

Please complete this form to terminate coverage for an employee and/or the employee's dependents.

Company Name			Customer #	
Employee Name – Last	First		Middle Initial	Social Security Number - -

Terminate coverage for:

Check one: ☐ Employee ☐ Dependents Only ☐ Spouse Only	☐ Children Only ☐ One Child Only, Provide Name: ___________	**Terminate coverage for (check all that apply):** ☐ Medical ☐ Dental ☐ Vision ☐ Life	**COBRA:** ☐ Offer COBRA ☐ Term COBRA	**Requested Term Date** ___/___/_____

REASON FOR TERMINATION OF COVERAGE (check one):

☐ Employee terminated employment. Last day of full-time employment: ___/___/_____	☐ Employee no longer eligible. Please explain:		
Employer Signature (in black ink)	**Print Name**	**EMAIL ADDRESS***	**Date**

☐ Other coverage	☐ Death	☐ Marriage	☐ Divorce	☐ Other: _______________

Employee Signature (in black ink)	**Print Name**	**EMAIL ADDRESS***	**Date**

Photocopy if more forms are required

* Email addresses are for sending confirmations only and will not be used for any other purposes.

To submit this request for termination of coverage:

Mail to:
BEST Life and Health Insurance Company
Attn. Administration
17701 Mitchell North
Irvine, CA. 92614-6028

Email to: changes@bestlife.com

Fax to: Attn. Administration, 949.724.1603

PLEASE NOTE: Do not make adjustments on your bill for terminated employees or dependents. When termination of coverage is processed, the adjustment will appear on your next bill.

TF0709

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