



Call/Fax:
Tel: 888-292-0272
FAX: 312-416-2860
E-mail:
NGBS.MemberTermination@alliedbenefit.com

Please complete and return via FAX or E-mail

FORM INSTRUCTIONS

Please complete the form and submit to Allied within 30 days of a member coverage termination. Member terminations submitted greater than 90 days retroactively will be subject to additional review.

EMPLOYER INFORMATION

Group Name

Group Number

EMPLOYEE INFORMATION

Employee Name

Last

First

Middle Initial

Employee Social
Security Number

Employee Date of Birth

MM

DD

CCYY

Employee
Address

City

State

Zip Code

TERMINATION INFORMATION

Date of
Insurance Term

Coverage Termination Date (last day covered under the plan):

MM

DD

CCYY

Please note that if the first day of the month is listed above then we will terminate to the last day of the previous month

*Coverage termination date should be on the 14th or last day of month depending on the group's policy effective date

Qualifying Event Reason (Must select only one)

☐ Employee's Termination or
Employee's Layoff

☐ Spouse's Divorce or Legal
Separation from Employee

☐ Employee's Death

☐ Dropping Coverage (specify on
form which member is to be
termed)

☐ Dependent Child Ceasing to
Qualify Under the Plan

☐ Terminate back to coverage
effective date (no coverage under
the plan)

☐ Medicare Entitlement

☐ Open Enrollment

☐ Employee's Reduction in Hours

Special Notes: _____

If a Termination of Employment was the Qualifying Event, please indicate whether the Termination was Voluntary or Involuntary:

☐ Involuntary

☐ Voluntary

EMPLOYEE/DEPENDENTS TO BE TERMINATED

Confirm below all participants that are to be terminated

Employee Name

Relationship

Gender

☐ M ☐ F

Birthdate (MM/DD/YYYY)

Social Security Number

Employee

Dependent Name(s)

Spouse

☐ M ☐ F

Child

☐ M ☐ F

Child

☐ M ☐ F

Child

☐ M ☐ F

Child

☐ M ☐ F

AUTHORIZATION

I certify that the above information is accurate. If applicable, I authorize Allied Benefit Systems, LLC to notify those individuals whom I have certified of their COBRA rights and creditable coverage.

Signature of Authorized Company Representative

Date

NGBS Office Use Only

Applicable if requested term date above is prior to 90-days
from the termination submission date

Approved Term Date / /20

Approved By _____