

## 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:**

<b>Check one:</b> <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Only <input type="checkbox"/> Spouse Only	<input type="checkbox"/> Children Only <input type="checkbox"/> One Child Only, Provide Name: _____	<b>Terminate coverage for (check all that apply):</b> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life	<b>COBRA:</b> <input type="checkbox"/> Offer COBRA <input type="checkbox"/> Term COBRA	<b>Requested Term Date</b> / /
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**REASON FOR TERMINATION OF COVERAGE (check one):**

<input type="checkbox"/> Employee terminated employment. Last day of full-time employment: ____ / ____ / ____	<input type="checkbox"/> Employee no longer eligible. Please explain:
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<b>Employer Signature (in black ink)</b>	<b>Print Name</b>	<b>EMAIL ADDRESS*</b>	<b>Date</b>
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<input type="checkbox"/> Other coverage	<input type="checkbox"/> Death	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Other: _____
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<b>Employee Signature (in black ink)</b>	<b>Print Name</b>	<b>EMAIL ADDRESS*</b>	<b>Date</b>
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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  
 2505 McCabe Way  
 Irvine, CA 92614

**Email to:** [cs@bestlife.com](mailto:cs@bestlife.com)

**Fax to:** Attn. Administration, 208.893.5040

**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.