BEST Life™
BEST Life and Health Insurance Company

Group #: _____

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

REASON FOR TERMINATION OF COVERAGE (check one):

☐ Employee terminated employment. Last day of full-time employment: _____	☐ Employee no longer eligible. Please explain:

Employer Signature	**Print Name**	**EMAIL ADDRESS***	**Date**

☐ Other coverage	☐ Death	☐ Marriage	☐ Divorce	☐ Other: _____

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
P.O. Box 3023
Meridian, ID 83680-3023

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.

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