Municipal Health Benefit Program

Coverage Termination Date:
____
MHBP Use Only

Termination Form

(for employee terminations only. If terminating dependents, please use Change form.)

Employee Information - All Fields Required Group Number: Group Name:

Employee First Name:	Employee Last Name:
Social Security Number:	Date of Birth:
Marital Status: Married / Single / Divorced (circle one)	Gender: Male / Female (circle one)
Full Mailing Address:	

Phone: (_____) ________________ Email:____

Reason for Termination:

☐Termination of employment: Last day of employment:________________________

☐Reduction of hours: Effective date of reduction:____________________________

☐Employee Death: Date of death:____________________

☐Medicare Eligible: Effective date of Medicare coverage:____________________

☐Military Leave: Last day of work before Leave:__________________________ (copy of orders required)

☐Member Requests Termination: Effective date of cancellation:_______________

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Employee Signature: ______________________________ **Date:**__________

(Employee signature not required for employment termination)

Group Rep. Signature: ______________________________ **Date:** __________

Eff 01.2022