MUNICIPAL HEALTH
P.O. BOX 188
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MUNICIPAL HEALTH

EMPLOYEE HEALTH BENEFIT TERMINATION FORM

DATE TO BE TERMED: _____ *Municipal Health Use Only*

GROUP NAME: _____ GROUP NUMBER: _____

1. EMPLOYEE INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Social Security Number _____

Marital Status: ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

2. REASON FOR TERMINATION

Termination of Employment—Last day of employment: _____

Reduction of Hours—Effective date of reduction: _____

Medicare Eligible—Date of Medicare eligibility: _____

Military Leave—Last day of work before leave: _____ (copy of orders required)

Employee Death—Date of death: _____

Member Request—Requested date of termination: _____

_____ _____

Signature of Employee (not required for terminated employees) **Date**

_____ _____

Signature of Group Representative **Date**

Please note: Incomplete forms will not be processed and will be returned for completion.

Save Form Print Form Clear Form