



Catholic Diocese of Sioux Falls  
 523 N Duluth Ave  
 Sioux Falls, SD 57104  
 FAX (605)988-3852

## EMPLOYEE BENEFITS TERMINATION OF COVERAGE

Please submit changes as they occur, one form per employee. Return completed form to Diocesan Human Resources Office.

SECTION A: EMPLOYEE INFORMATION			
NAME (Last, First, MI):	SOCIAL SECURITY NUMBER:	PHONE NUMBER:	
ADDRESS (Number, Street, Apt#):	CITY:	STATE:	ZIP:
EMAIL:		LOCATION EMPLOYED:	

SECTION B: PLAN TERMINATION DUE TO QUALIFYING EVENT		
CANCEL CODE (See Below)	DATE OF EVENT	LAST DATE OF COVERAGE
BENEFIT PLANS YOU ARE CHOOSING TO TERMINATE (Check all that apply): <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> LIFE <input type="checkbox"/> LTD		

SECTION C: VOLUNTARY TERMINATION OF SPOUSE AND/OR DEPENDENT COVERAGE				
The Diocesan Health Plan <b>requires</b> the signed consent from the employee for any voluntary termination of coverage. In the event that the termination also includes the employee's spouse, the spouse must also sign this form.				
SPOUSE OR DEPENDENT NAME	CANCEL CODE (See Below)	DATE OF EVENT	PLAN(S) TERMINATING	LAST DAY OF COVERAGE
			<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> LIFE <input type="checkbox"/> LTD	
			<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> LIFE <input type="checkbox"/> LTD	
			<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> LIFE <input type="checkbox"/> LTD	
Spouse Signature: _____		Date: _____		

CANCEL CODE LIST:			
01 TERMINATION OF EMPLOYMENT	03 MARRIAGE, DIVORCE OR LEGAL SEPARATION	05 BIRTH OR ADOPTION OF A CHILD	07 MEDICARE
02 REDUCTION IN HOURS (FT TO PT)	04 CHILD LOSS OF DEPENDENT STATUS	06 DEATH OF A SPOUSE OR CHILD	08 OTHER (please explain)

By signing this form, I understand that the benefits I have indicated above will be terminated on the last day of the month in which the termination was requested or the last day of the month in which the form is received by the Diocesan Human Resources Office, whichever is later.

Employee Signature: _____	Date: _____
Benefit Coordinator Signature: _____	Date: _____
Location Employed: _____	City: _____