# VOLUNTARY TERMINATION OF COVERAGE

*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: |
| LOCATION EMPLOYED: | | EMAIL: | |

| SECTION B: PLAN TERMINATION DUE TO QUALITYING EVENT | | |
|---|---|---|
| COMPLETE THIS SECTION IF YOU ARE TERMINATING A PLAN FOR YOURSELF AND ALL OF YOUR DEPENDENTS | | |
| CANCEL CODE (See Below) | DATE OF EVENT | LAST DATE OF COVERAGE |
| BENEFIT PLANS YOU ARE CHOOSING TO TERMINATE (Check all that apply): ☐ MEDICAL ☐ DENTAL ☐ LIFE ☐ LTD | | |

| SECTION C: VOLUNTARY TERMINATION OF SPOUSE AND/OR DEPENDENT COVERAGE | | | | |
|---|---|---|---|---|
| COMPLETE THIS SECTION IF YOU ARE REMOVING A DEPENDENT FROM A PLAN | | | | |
| The Diocesan Health Plan **requires** 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 |
| | | | ☐ MEDICAL ☐ DENTAL ☐ LIFE ☐ LTD | |
| | | | ☐ MEDICAL ☐ DENTAL ☐ LIFE ☐ LTD | |
| | | | ☐ MEDICAL ☐ DENTAL ☐ LIFE ☐ 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: ______________________

Location Benefit Coordinator Signature: ______________________ Date: ______________________

Location Employed: ______________________ City: ______________________