



**S.C. Public Employee Benefit Authority
Insurance Benefits
Active Termination Form**

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To be completed by Benefits Administrator

If completing by hand use black ink

A. A C T I O N	REASONS FOR TERMINATION (Check one): <input type="checkbox"/> NOT ELIGIBLE (Not in stability period) (T5) • Resigned or terminated from employment • No longer eligible for benefits Last Day Worked: _____ <input type="checkbox"/> TRANSFER (TT): Group ID #: _____ Group Name: _____ <input type="checkbox"/> MILITARY LEAVE (TM)				<input type="checkbox"/> NONPAYMENT (TN) <input type="checkbox"/> SERVICE RETIREMENT (T7) • Regular • Police • GA • Judicial <input type="checkbox"/> DISABILITY RETIREMENT (T2) <input type="checkbox"/> DECEASED (T1) Date of Death: _____ <input type="checkbox"/> REDUCTION IN HOURS OR UNPAID LEAVE (IN STABILITY PERIOD) (TH)			
B. E N R .	1. Social Security Number		2. Group ID Number		3. Group Name			
	4. Last Name		5. Suffix	6. First Name		7. MI		
C. P L A N / D E P E N D E N T S	CHECK COVERAGE(S) TO TERMINATE: Effective Date: _____ Effective Date: _____ <input type="checkbox"/> HEALTH, BASIC LIFE, BASIC LTD <input type="checkbox"/> OPTIONAL LIFE <input type="checkbox"/> DENTAL/DENTAL PLUS <input type="checkbox"/> VISION <input type="checkbox"/> DEPENDENT LIFE/CHILD <input type="checkbox"/> DEPENDENT LIFE/SPOUSE <input type="checkbox"/> SUPPLEMENTAL LONG TERM DISABILITY <input type="checkbox"/> MONEYPLUS (Notification: To MoneyPlus administrator-Medical Spending Account only)							
D. C E R T .	I HEREBY ATTEST THAT THE TERMINATION REASON IS CORRECT AND ACCURATE TO THE BEST OF MY KNOWLEDGE. THE ABOVE EMPLOYEE HAS BEEN OFFERED EITHER COBRA, DISABILITY OR SERVICE RETIREMENT INFORMATION, AND/OR ANY OTHER PERTINENT INFORMATION REGARDING CONTINUATION OR CONVERSION OF COVERAGE ACCORDING TO HIS/HER TYPE OF TERMINATION. FURTHERMORE, THIS EMPLOYEE AND ALL INTERNAL DEPARTMENTS HAVE BEEN NOTIFIED THAT THE INSURANCE COVERAGES HAVE BEEN TERMINATED AND A COPY OF THIS FORM HAS BEEN GIVEN/MAILED TO THE EMPLOYEE AND HEALTH PLAN FOR APPROPRIATE ACTION. CLAIMS WILL NOT BE HONORED AFTER THE DATE OF TERMINATION BY ANY CARRIER, UNLESS COVERAGE IS REINSTATED WITH THE APPROPRIATE APPLICATION. IF APPLICABLE, CHECK ONE OR MORE APPROPRIATE OPTIONS OFFERED. <input type="checkbox"/> COBRA <input type="checkbox"/> RETIREE <input type="checkbox"/> CONVERSION <input type="checkbox"/> PORTABILITY <input type="checkbox"/> INSURANCE BENEFITS WHEN HOURS ARE REDUCED Benefits Administrator's signature: _____ Date: _____							
EMPLOYEE NOTE: THIS FORM IS PROVIDED FOR INFORMATION ONLY. IT IS YOUR RESPONSIBILITY TO COMPLETE THE APPROPRIATE PLAN APPLICATION(S) FOR CONTINUATION OPTIONS UNDER EACH COVERAGE TERMINATION.								
PEBA INSURANCE BENEFITS/FLEXIBLE BENEFITS ADMINISTRATION USE ONLY								

INSTRUCTIONS

Type/Print In Black Ink

- A. ACTION:** Reason For Termination: Check appropriate block for termination reason. If enrollee is transferring to another participating employer, give name of employer and group number.
- B. ENROLLEE:** Entire Section (Blocks 1-7) must be completed for all transactions.
- C. PLANS/DATES:** Check plan(s) to be terminated and give effective date(s) for each plan. If terminating employee is contributing to a MoneyPlus Medical Spending Account, send a copy of this form to the MoneyPlus Administrator.

BAs should send a copy of the form to:

WageWorks
Benefits Continuation Department
Post Office Box 1878
Tallahassee, FL 32302-1878

- D. CERTIFICATION:** Benefits Administrator must sign and date this form before submitting it to PEBA. Your signature attests that the termination reason is correct; the employee has been given a copy of this termination; COBRA or other continuation of coverage has been offered; and payroll has been notified. If continuation of benefits are offered, check block for each type.