south carolina peba SM
state health plan | retirement systems

Serving those who serve South Carolina

Active Termination Form

To be completed by a benefits administrator. Use black ink if completing by hand.

Reason for termination (check one):

- ☐ Not eligible (not in stability period) (T5)
  Resigned or terminated from employment
  No longer eligible for benefits
  Last day worked: _____
- ☐ Transfer (TT):
  Group ID #: _____
  Group name: _____
- ☐ Military leave (TM)
- ☐ Reduction in hours or unpaid leave (in stability period) (TH)
- ☐ Nonpayment (TN)
- ☐ Service retirement (T7)
  Regular / Police / GA / Judicial
- ☐ Disability retirement (T2)
- ☐ Deceased (T1)
  Date of death:_____

Employee information

1. Social Security number or BIN	2. Group ID number	3. Group name	
4. Last name	5. Suffix	6. First name	7. M.I.

Select coverage(s) to terminate:

Effective date: _____

- ☐ Health, Basic Life, Basic Long Term Disability
- ☐ Dental/Dental Plus
- ☐ Vision
- ☐ Optional Life
- ☐ Dependent Life-Spouse
- ☐ Dependent Life-Child
- ☐ Supplemental Long Term Disability
- ☐ MoneyPlus (Notify MoneyPlus vendor for Medical Spending Account)

Certification

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 any other pertinent information regarding continuation or conversion of coverage according to his termination type. Furthermore, this employee and all internal departments have been notified that insurance coverages have been terminated and a copy of this form has been given or 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 on or more appropriate options offered below.

☐ COBRA ☐ Retiree ☐ Conversion ☐ Portability ☐ Insurance benefits when hours are reduced

Benefits administrator signature: _____ Date: _____

Employee note: This form is provided for information only. It is your responsibility to complete the appropriate plan application(s) for continuation/conversion options under each coverage termination.

PEBA/flexible benefits vendor use only

Instructions

Type or use black ink if completing by hand.

1. **Reason for termination**
   Check appropriate block for termination reason. If employee is transferring to another participating employer, give name of employer and group number.

2. **Employee information**
   Complete blocks 1-7 for all transactions.

3. **Select coverage(s) to terminate**
   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 vendor at the address below.

   WageWorks
   P.O. Box 14766
   Lexington, KY 40512-4766

4. **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.