PEBA
SC Retirement Systems and State Health Plan

South Carolina Public Employee Benefit Authority
Serving those who serve South Carolina

Active Termination Form

Submit terminations in EBS if possible. Use black ink if completing by hand.

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

Reason for termination (check one):

- ☐ Not eligible (not in stability period) (T5)
  Resigned or terminated from employment
  No longer eligible for benefits
- ☐ Transfer (TT):
  Group ID #: _____
  Employer 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:_____

Dates

Date of termination from employment: _____ Last day of earned compensation: _____
Date of final paycheck: _____ Date of termination: _____

Select coverage(s) to terminate:

- ☐ Health, Basic Life, Basic Long Term Disability
- ☐ Basic Dental/Dental Plus
- ☐ Vision
- ☐ Optional Life
- ☐ Dependent Life-Spouse
- ☐ Dependent Life-Child
- ☐ Supplemental Long Term Disability
- ☐ MoneyPlus

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 from employment by any carrier, unless coverage is reinstated with the appropriate application. If applicable, check one 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 use only

Instructions

Type or use black ink if completing by hand.

Employee information
Complete blocks 1-7 for all transactions.

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

Dates
Enter these dates:

- The *Date of termination from employment* is the date the employee is formally terminated from employment. The employee is no longer earning wages; however, a final paycheck may be issued at a later date.
- The *Last day of earned compensation* is the last day the employee earned compensation. It must be the same as or prior to the employee's date of termination from employment. It cannot be later than the date of termination from employment.
- The *Date of final paycheck* is the date of the employee's last paycheck. This will be an optional field.
- The *Date of termination* is the date that benefits will terminate.

PEBA will use the *Date of termination from employment* to calculate the date to terminate coverage.

Select coverage(s) to terminate
Check plan(s) to be terminated and give effective date(s) for each plan.

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 is offered, check block for each type.