MED-PAY, INC.
TERMINATION OF COVERAGE NOTIFICATION

FAX: (417) 886-2276
WWW.MED-PAY.COM

*Submitter: _____

*Company Name: _____

*Date Submitted: _____

*Employee Name: _____

*Identification Number: _____

Please mark applicable boxes with "X"

*Individual(s) Termination Applies to: ☐ Employee/Retiree ☐ Spouse ☐ Children ☐ All

If child-specific, please note each child's name: _____

*Coverage(s) Termination Applies to: ☐ Medical ☐ Dental ☐ Vision ☐ STD ☐ Life ☐ Supp Life ☐ LTD ☐ All

*Termination Date: _____
(Please note 1st day of non-coverage)

Change of Address: _____

_____

Change of Address Applies to: ☐ Employee/Retiree ☐ Spouse ☐ Children ☐ All

Please mark applicable box with "X"
***COVERAGE TERMINATION REASON**

	Voluntary	COBRA/Subsidy		Involuntary	COBRA/Subsidy
Active Employee:					
Elective Termination of Employment	☐	18/N	Employer-imposed termination:		
Elective Retirement	☐	18/N	Fired	☐	18/Y
Elective Drop of Coverage	☐	N/N	Fired due to Gross Misconduct	☐	N/N
Death of Employee	☐	36/N	Layoff	☐	18/Y
Medicare Enrollment/Eligibility (Eff date: _____)	☐	18/N	Mandatory Retirement	☐	18/Y
Reduction of Hours	☐	18/N	Severance Program	☐	18/Y
			Failure to return from leave	☐	18/Y
			Employee-initiated termination:		
			Upon Material Reduction of Hours Upon Material Reduction of Pay Upon Relocation of Job Other Material Change	☐	18/Y
Retirees:					
Medicare Enrollment/Eligibility (Eff date: _____)	☐	N/N			
Elective Drop of Coverage	☐	N/N			
Death of Retiree	☐	N/N			
Spouse:					
Death of Spouse	☐	N/N			
Divorce or Legal Separation	☐	36/N			
Child(ren):					
Death of Dependent Child	☐	N/N			
Marriage of Dependent Child	☐	36/N			
Not a Full-Time Student	☐	36/N			
College Graduation of Dependent Child	☐	36/N			
Limiting Age Reached	☐	36/N			
No Longer Dependent Upon Insured	☐	36/N			
COBRA Participants:					
COBRA Period Expired	☐	N/N			
Elective Termination of COBRA	☐	N/N			
Other Group Health Insurance (Eff date: _____)	☐	N/N			

COMMENTS/OTHER:

_____

_____

_____