



Call/Fax:  
 Tel: 888-292-0272  
 FAX: 312-416-2860  
 E-mail:  
[NGBS.MemberTermination@alliedbenefit.com](mailto:NGBS.MemberTermination@alliedbenefit.com)

Please complete and return via FAX or E-mail

**FORM INSTRUCTIONS**

Please complete the form and submit to Allied within 30 days of a member coverage termination. Member terminations submitted greater than 90 days retroactively will be subject to additional review.

**EMPLOYER INFORMATION**

**Group Name** \_\_\_\_\_  
**Group Number** \_\_\_\_\_

**EMPLOYEE INFORMATION**

**Employee Name**

<b>Last</b>	<b>First</b>	<b>Middle Initial</b>
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**Employee Social Security Number** \_\_\_\_\_ **Employee Date of Birth** MM DD CCYY

**Employee Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**TERMINATION INFORMATION**

**Date of Insurance Term** \_\_\_\_\_ **Coverage Termination Date (last day covered under the plan):** MM DD CCYY

Please note that if the first day of the month is listed above then we will terminate to the last day of the previous month

\*Coverage termination date should be on the 14<sup>th</sup> or last day of month depending on the group's policy effective date

**Qualifying Event Reason (Must select only one)**

<input type="checkbox"/> Employee's Termination or Employee's Layoff	<input type="checkbox"/> Spouse's Divorce or Legal Separation from Employee	<input type="checkbox"/> Employee's Death	<input type="checkbox"/> Dropping Coverage (specify on form which member is to be termed)
<input type="checkbox"/> Dependent Child Ceasing to Qualify Under the Plan	<input type="checkbox"/> Terminate back to coverage effective date (no coverage under the plan)	<input type="checkbox"/> Medicare Entitlement	<input type="checkbox"/> Employee's Reduction in Hours
		<input type="checkbox"/> Open Enrollment	

Special Notes: \_\_\_\_\_

**If a Termination of Employment was the Qualifying Event, please indicate whether the Termination was Voluntary or Involuntary:**

Involuntary  Voluntary

**EMPLOYEE/DEPENDENTS TO BE TERMINATED** Confirm below all participants that are to be terminated

Employee Name	Relationship	Gender	Birthdate (MM/DD/YYYY)	Social Security Number
	Employee	<input type="checkbox"/> M <input type="checkbox"/> F		
<b>Dependent Name(s)</b>				
	Spouse	<input type="checkbox"/> M <input type="checkbox"/> F		
	Child	<input type="checkbox"/> M <input type="checkbox"/> F		
	Child	<input type="checkbox"/> M <input type="checkbox"/> F		
	Child	<input type="checkbox"/> M <input type="checkbox"/> F		
	Child	<input type="checkbox"/> M <input type="checkbox"/> F		

**AUTHORIZATION**

I certify that the above information is accurate. *If applicable*, I authorize Allied Benefit Systems, Inc. to notify those individuals whom I have certified of their COBRA rights and creditable coverage.

\_\_\_\_\_  
 Signature of Authorized Company Representative

\_\_\_\_\_  
 Date

<b>NGBS Office Use Only</b>	Applicable if requested term date above is prior to 90-days from the termination submission date  Approved Term Date     /     /20	Approved By _____
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