of Tennessee

1 Cameron Hill Circle
Chattanooga, TN 37402-0001
bcbst.com

- CONFIDENTIAL -

TERMINATION

PLEASE USE BLUE OR BLACK INK ONLY

Plan Use Only
Rec:____________

TRM-15

By submission of this form, the group certifies that, if any termination of coverage date supplied will result in a retroactive termination, such termination is in compliance with the Patient Protection and Affordable Care Act.

INSTRUCTIONS: Complete Section:
- **1 to terminate Employee/Elect Continuation Coverage**
- **1 to terminate Employee and all Dependents/Elect Continuation Coverage for Employee and all Dependents**
- **1 & 2 to terminate Employee/Elect Continuation Coverage for Some Dependents**
- **2 to terminate Specific Dependents/Elect Continuation Coverage**

If you purchased COBRA Administration from BlueCross BlueShield of Tennessee, do not complete this form. Instead, complete the COBRA Coverage Continuation Notice (CCN) online at bcbst.com.
If Employee elects COBRA/State Continuation at a later date, fill out Employee Enrollment/Waiver Form.

GROUP NO. | GROUP NAME | BLUECROSS BLUESHIELD OF TN BILLING ASSOCIATE

Section 1 - Employee Termination

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO. | TERMINATION DATE OF COVERAGE __/__/____

COVERAGE TO TERMINATE: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ LIFE ☐ HEALTH CARE FSA ☐ DEPENDENT CARE FSA

REASON: ☐ TERMINATION OF EMPLOYMENT ☐ REDUCTION IN HOURS ☐ NO LONGER ELIGIBLE EMPLOYEE ☐ DEATH ☐ MEDICARE ELIGIBLE ☐ OTHER

STATE CONTINUATION OF COVERAGE (Groups under 20) ☐ MEDICAL ☐ DENTAL ☐ VISION | COBRA COVERAGE (Groups of 20 or more) ☐ MEDICAL ☐ DENTAL ☐ VISION | COBRA SUBGROUP | DEPARTMENT NO. | QUALIFYING EVENT DATE __/__/____

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO. | TERMINATION DATE OF COVERAGE __/__/____

COVERAGE TO TERMINATE: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ LIFE ☐ HEALTH CARE FSA ☐ DEPENDENT CARE FSA

REASON: ☐ TERMINATION OF EMPLOYMENT ☐ REDUCTION IN HOURS ☐ NO LONGER ELIGIBLE EMPLOYEE ☐ DEATH ☐ MEDICARE ELIGIBLE ☐ OTHER

STATE CONTINUATION OF COVERAGE (Groups under 20) ☐ MEDICAL ☐ DENTAL ☐ VISION | COBRA COVERAGE (Groups of 20 or more) ☐ MEDICAL ☐ DENTAL ☐ VISION | COBRA SUBGROUP | DEPARTMENT NO. | QUALIFYING EVENT DATE __/__/____

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO. | TERMINATION DATE OF COVERAGE __/__/____

COVERAGE TO TERMINATE: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ LIFE ☐ HEALTH CARE FSA ☐ DEPENDENT CARE FSA

REASON: ☐ TERMINATION OF EMPLOYMENT ☐ REDUCTION IN HOURS ☐ NO LONGER ELIGIBLE EMPLOYEE ☐ DEATH ☐ MEDICARE ELIGIBLE ☐ OTHER

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COVERAGE TO TERMINATE: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ LIFE ☐ HEALTH CARE FSA ☐ DEPENDENT CARE FSA

REASON: ☐ TERMINATION OF EMPLOYMENT ☐ REDUCTION IN HOURS ☐ NO LONGER ELIGIBLE EMPLOYEE ☐ DEATH ☐ MEDICARE ELIGIBLE ☐ OTHER

STATE CONTINUATION OF COVERAGE (Groups under 20) ☐ MEDICAL ☐ DENTAL ☐ VISION | COBRA COVERAGE (Groups of 20 or more) ☐ MEDICAL ☐ DENTAL ☐ VISION | COBRA SUBGROUP | DEPARTMENT NO. | QUALIFYING EVENT DATE __/__/____

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Completed by: ____________ Phone Number: ____________ Date: __/__/____

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

Section 2 - Spouse / Dependent(s) Termination

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO. | TERMINATION DATE OF COVERAGE

❑ I WISH TO CHANGE TO SUBSCRIBER ONLY COVERAGE. APPLIES TO: ❑ MEDICAL ❑ DENTAL ❑ VISION [DO NOT LIST SPOUSE/DEPENDENT(S)]

❑ I WISH TO TERMINATE ONLY THE SPOUSE/DEPENDENT(S) LISTED BELOW.

DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | DEPENDENT SSN/TIN | DATE OF BIRTH | TERMINATION DATE

COVERAGE TO TERMINATE
❑ MEDICAL ❑ DENTAL ❑ VISION

REASON: ❑ NO LONGER ELIGIBLE DEPENDENT ❑ DIVORCE ❑ MEDICARE ELIGIBLE ❑ DEATH OF DEPENDENT ❑ DEATH OF SUBSCRIBER OTHER

STATE CONTINUATION OF COVERAGE (Groups under 20)
❑ MEDICAL ❑ DENTAL ❑ VISION

COBRA COVERAGE (Groups of 20 or more)
❑ MEDICAL ❑ DENTAL ❑ VISION

COBRA SUBGROUP | DEPARTMENT NO. | QUALIFYING EVENT DATE

NEW ADDRESS FOR DEPENDENT

DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | DEPENDENT SSN/TIN | DATE OF BIRTH | TERMINATION DATE

COVERAGE TO TERMINATE
❑ MEDICAL ❑ DENTAL ❑ VISION

REASON: ❑ NO LONGER ELIGIBLE DEPENDENT ❑ DIVORCE ❑ MEDICARE ELIGIBLE ❑ DEATH OF DEPENDENT ❑ DEATH OF SUBSCRIBER OTHER

STATE CONTINUATION OF COVERAGE (Groups under 20)
❑ MEDICAL ❑ DENTAL ❑ VISION

COBRA COVERAGE (Groups of 20 or more)
❑ MEDICAL ❑ DENTAL ❑ VISION

COBRA SUBGROUP | DEPARTMENT NO. | QUALIFYING EVENT DATE

NEW ADDRESS FOR DEPENDENT

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO. | TERMINATION DATE OF COVERAGE

❑ I WISH TO CHANGE TO SUBSCRIBER ONLY COVERAGE. APPLIES TO: ❑ MEDICAL ❑ DENTAL ❑ VISION [DO NOT LIST SPOUSE/DEPENDENT(S)]

❑ I WISH TO TERMINATE ONLY THE SPOUSE/DEPENDENT(S) LISTED BELOW.

DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | DEPENDENT SSN/TIN | DATE OF BIRTH | TERMINATION DATE

COVERAGE TO TERMINATE
❑ MEDICAL ❑ DENTAL ❑ VISION

REASON: ❑ NO LONGER ELIGIBLE DEPENDENT ❑ DIVORCE ❑ MEDICARE ELIGIBLE ❑ DEATH OF DEPENDENT ❑ DEATH OF SUBSCRIBER OTHER

STATE CONTINUATION OF COVERAGE (Groups under 20)
❑ MEDICAL ❑ DENTAL ❑ VISION

COBRA COVERAGE (Groups of 20 or more)
❑ MEDICAL ❑ DENTAL ❑ VISION

COBRA SUBGROUP | DEPARTMENT NO. | QUALIFYING EVENT DATE

NEW ADDRESS FOR DEPENDENT

DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | DEPENDENT SSN/TIN | DATE OF BIRTH | TERMINATION DATE

COVERAGE TO TERMINATE
❑ MEDICAL ❑ DENTAL ❑ VISION

REASON: ❑ NO LONGER ELIGIBLE DEPENDENT ❑ DIVORCE ❑ MEDICARE ELIGIBLE ❑ DEATH OF DEPENDENT ❑ DEATH OF SUBSCRIBER OTHER

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COBRA SUBGROUP | DEPARTMENT NO. | QUALIFYING EVENT DATE

NEW ADDRESS FOR DEPENDENT