

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

PLEASE USE BLUE OR BLACK INK ONLY

Plan Use Only	
Rec:	

**TRM-15** 

- CONFIDENTIAL -

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

<u> </u>	DOUBNAME	at Employed Embiniona		SS BLUESHIELD OF TN BILLING ASSOCIATE		
GROUP NO.	GROUP NAME		7	355 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:   MED	DICAL DENTAL DIVISION LIFE	☐ HEALTH CARE FSA	DEPENDENT C	ARE FSA		
REASON: TERMINATION OF EMP	LOYMENT   REDUCTION IN HOURS   NO	LONGER ELIGIBLE EMPLO	OYEE 🔲 DEATH	☐ MEDICARE ELIGIBLE ☐ OTHER		
STATE CONTINUATION OF COVERAGE (G	Groups under 20) COBRA COVERAGE (Groups of 20	or more)	COBRA SUBGROUP	DEPARTMENT NO.	QUALIFYING EVENT DATE	
☐ MEDICAL ☐ DENTAL ☐ VIS		VISION				
EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME	MI	IDENTIFICATION	NO.	TERMINATION DATE OF COVERAGE	
COVERAGE TO TERMINATE:   MED	DICAL DENTAL DIVISION DILIFE	☐ HEALTH CARE FSA	DEPENDENT C	ARE FSA		
REASON: TERMINATION OF EMP	LOYMENT   REDUCTION IN HOURS   NO	LONGER ELIGIBLE EMPLO	OYEE 🔲 DEATH	☐ MEDICARE ELIGIBLE ☐ OTHER		
STATE CONTINUATION OF COVERAGE (G	Groups under 20) COBRA COVERAGE (Groups of 20	or more)	COBRA SUBGROUP	DEPARTMENT NO.	QUALIFYING EVENT DATE	
☐ MEDICAL ☐ DENTAL ☐ VIS	/ Landau and American and Ameri					
EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME	MI	IDENTIFICATION	NO.	TERMINATION DATE OF COVERAGE	
COVERAGE TO TERMINATE:   MED	DICAL DENTAL VISION LIFE	☐ HEALTH CARE FSA	■ DEPENDENT C	ARE FSA		
REASON: TERMINATION OF EMP	LOYMENT REDUCTION IN HOURS NO	LONGER ELIGIBLE EMPLO	OYEE 🗖 DEATH	☐ MEDICARE ELIGIBLE ☐ OTHER		
STATE CONTINUATION OF COVERAGE (G	Groups under 20) COBRA COVERAGE (Groups of 20	or more)	COBRA SUBGROUP	DEPARTMENT NO.	QUALIFYING EVENT DATE	
☐ MEDICAL ☐ DENTAL ☐ VIS						
EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME	MI	IDENTIFICATION	NO.	TERMINATION DATE OF COVERAGE	
COVERAGE TO TERMINATE:	DICAL DENTAL DIVISION DILIFE	☐ HEALTH CARE FSA	☐ DEPENDENT C	ARE FSA		
REASON:  TERMINATION OF EMP	LOYMENT   REDUCTION IN HOURS   NO	LONGER ELIGIBLE EMPLO	OYEE 🔲 DEATH	☐ MEDICARE ELIGIBLE ☐ OTHER		
STATE CONTINUATION OF COVERAGE (G	Groups under 20) COBRA COVERAGE (Groups of 20	) or more)	COBRA SUBGROUP	DEPARTMENT NO.	QUALIFYING EVENT DATE	
☐ MEDICAL ☐ DENTAL ☐ VIS						
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 Numb	ner	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 ON	NLY COVERAGE. APPLIES TO:	☐ DENTAL ☐ VISION [DO NOT LIST SPOUSE/DE	PENDENT(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 DEATH OF DEATH OF SUBSCRIBER OTHER				
STATE CONTINUATION OF COVERAGE (Groups under 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 DIVORCE	MEDICARE DEATH OF DEATH OF □ ELIGIBLE □ DEPENDENT □ SUBSCRIBER OTHER				
STATE CONTINUATION OF COVERAGE (Groups under MEDICAL DENTAL DENTAL VISION	COBRA COVERAGE (Groups of 20 or more)  MEDICAL DENTAL VISION	COBRA SUBGROUP DEPARTMENT NO.	QUALIFYING EVENT DATE			
NEW ADDRESS FOR DEPENDENT						
EMPLOYEE LACT MAME						
EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME MI	IDENTIFICATION NO.	TERMINATION DATE OF COVERAGE			
□ I WISH TO CHANGE TO SUBSCRIBER ON		IDENTIFICATION NO.				
	NLY COVERAGE. APPLIES TO: MEDICAL					
☐ I WISH TO CHANGE TO SUBSCRIBER ON	NLY COVERAGE. APPLIES TO: MEDICAL					
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☐ I WISH TO CHANGE TO SUBSCRIBER ON ☐ I WISH TO TERMINATE ONLY THE SPOUNDEPENDENT LAST NAME ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	NLY COVERAGE. APPLIES TO: MEDICAL SE/DEPENDENT(S) LISTED BELOW.  DEPENDENT FIRST NAME MI  LISTED BELOW.  DEPENDENT IN DIVORCE	DEPENDENT SSN/TIN  MEDICARE  DENTAL  VISION  [DO NOT LIST SPOUSE/DEI  DATE OF BIRTH	PENDENT(S)]			
☐ I WISH TO CHANGE TO SUBSCRIBER ON ☐ I WISH TO TERMINATE ONLY THE SPOUNDEPENDENT LAST NAME ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	NLY COVERAGE. APPLIES TO: MEDICAL SE/DEPENDENT(S) LISTED BELOW.  DEPENDENT FIRST NAME MI  REASON: NO LONGER ELIGIBLE DIVORCE  20) COBRA COVERAGE (Groups of 20 or more)	DEPENDENT SSN/TIN DATE OF BIRTH MEDICARE DEATH OF DEPENDENT DEATH OF DEATH OF SUBSCRIBER OTHER	PENDENT(S)]  TERMINATION DATE			
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□ I WISH TO CHANGE TO SUBSCRIBER ON □ I WISH TO TERMINATE ONLY THE SPOUNDEPENDENT LAST NAME □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	NLY COVERAGE. APPLIES TO: MEDICAL  SE/DEPENDENT(S) LISTED BELOW.  DEPENDENT FIRST NAME MI  REASON: NO LONGER ELIGIBLE DEPENDENT DIVORCE  120) COBRA COVERAGE (Groups of 20 or more) MEDICAL DENTAL VISION  DEPENDENT FIRST NAME MI  REASON: NO LONGER ELIGIBLE DEPENDENT DIVORCE	DEPENDENT SSN/TIN  MEDICARE  DEPENDENT  DEPE	PENDENT(S)]  TERMINATION DATE			