

Insurance Termination Form

WANADA recommends that you email all termination forms to your WANADA account representative for tracking purposes. If you do not receive a confirmation email from your account rep, you can assume that it was not received. If you cannot email, you may fax your form to (202) 237-7779. Please note that a confirmation page from your fax machine does not constitute a successful transmission. If you fax your terminations, please follow up via email with your account representative to confirm they are in receipt of this form and have all of the necessary information they need to process it. Also note that an incomplete termination form does not constitute a successful transmission. If there is missing information, the termination cannot be completed until all missing information is supplied. If a termination is not completed in a timely fashion, it will be up to the group to supply email documentation from a WANADA account representative verifying that they are in receipt of the form and have completed the termination to have any employee terminated from any plan retroactively more than 30 days.

1	Today's Date					
2	EMPLOYER NAME					
3	Employee Name					
4	Social Security Number (last 4 only)					
5	Date of Birth					
6	Address (Line 1)					
	Address (Line 2)					
7	City					
	State					
	Zip Code					
8	Dependent Coverage?					
9	Dependent Name/Dependent Date of Birth					
	Dependent Name/Dependent Date of Birth					
	Dependent Name/Dependent Date of Birth					
	Dependent Name/Dependent Date of Birth					
	Dependent Name/Dependent Date of Birth					
	<i>If the dependent's address is different from employee's, enter address here:</i>					
10	Drop Medical Coverage?	Yes	No	If yes, please write the type of plan:		
11	Drop Dental Coverage?	Yes	No	If yes, please mark the plan to drop:		
				#1	#2	#3
12	Drop Other Coverage? <i>i.e., vision, life, disability and/or other voluntary products</i>	Yes	No	If yes, please list which plans to drop:		
13	Qualifying Event (Select ONE event from list below)	# ____				
14	Date of Qualifying Event or Last Day of Employment					
15	Expiration Date of Coverage					
16	Was the employee terminated prior to the effective date of their coverage?	Yes	No			

Qualifying Event

- | | |
|--|----------------------------|
| 1 Termination of Employment | 5 Disabled |
| 2 Divorce/Legal Separation | 6 Medicare Entitlement |
| 3 Deceased | 7 Medical Leave |
| 4 Voluntary Drop of Insurance
(only allowed during open enrollment) | 8 Loss of Dependent Status |
| | 9 Reduction of Hours |

