



NORTH AMERICAN DIVISION BENEFITS

Health Care

HEALTH CARE EMPLOYEE BENEFITS TERMINATION REQUEST FORM

EMPLOYEE INSTRUCTIONS:

This form is to be completed only when a change needs to be made for an existing employee. Do not complete this form to add a new employee; an enrollment application must be completed for this purpose. However, this form may be used to add or terminate a spouse or child and to terminate an existing employee. This form may be completed by the employee, but must be signed by the employer before it is sent to Adventist Risk Management®, Inc. - Health Benefits Services.

EMPLOYEE INFORMATION:

NAME:

SSN#

TERMINATIONS TO BE MADE: *Mark Choice*

Termination Employee/Family

Termination Spouse

Child / Children

CHANGE DETAILS: (Fill in details for above marked choice)

LIST NAME OF EACH DEPENDANT OR SPOUSE TO BE TERMINATED							
FIRST NAME	M.I.	LAST NAME	BIRTHDATE (MM/DD/YYYY)	Sex	DEPENDANT'S SSN#	OTHER INSURANCE	
						YES/NO	PRIMARY / SECONDARY

OTHER INSURANCE NAME:

PHONE#:

EFFECTIVE DATE:
(MM/DD/YYYY)

EMPLOYEE SIGNATURE:

DATE SIGNED:
(MM/DD/YYYY)

This form can be submitted electronically to: HEALTHCAREELIGIBILITY@adventistrisk.org
(You **must** save the document to your computer then attach it to the e-mail generated by the link above)

OFFICE USE ONLY

AUTHORIZED EMPLOYER'S SIGNATURE REQUIRED

EMPLOYER NAME	EFFECTIVE DATE (MM/DD/YYYY)	GROUP #	SUBGROUP #

RECEIVED ON:

IBC				
TRANS#				
CARD	IBC			
CARD	ARM			
VERIFIED	IBC	WEB	UCD	RX
HIPPA CERT				

FOR ARM OFFICE USE ONLY

EMPLOYER SIGNATURE*:

DATE (MM/DD/YYYY):

SIGNATORY'S NAME:

COVERAGE CODE:

SIGNATORY'S TITLE:

***Please enter your initials to serve as your digital signature.**

By entering your initials and sending this form attached to an e-mail from your e-mail account, we will consider this form signed by you.

OFFICE USE ONLY