

TERMINATION/WAIVE NOTICE

Company Name: _____

PIBT Account No.: _____

Employee information:

Termination Date Requested _____

(Must be end of month and not more than one month from date received)

Name _____ Email Address _____

PIBT ID _____ or SSN XXX-XX-_____ Phone (_____) _____

Current Address _____ City _____ State _____ ZIP _____

Type of termination (check one only):

- Employee and Dependent(s), if any Spouse only Child(ren) only
 Spouse and Child(ren) Only Domestic Partner Only

Dependent(s) information:

Spouse _____ or Domestic Partner _____

Child _____ Child _____

Child _____ Child _____

Coverage type to be terminated or waived (check all that apply):

- Medical Dental Vision Chiropractic Mental Health
 Medical Term Life Supplemental Life Voluntary/MGL Life All coverage

Qualifying event for COBRA or State Continuation Coverage (Reason must be given - check one only):

Termination of employment:

- Voluntary Involuntary
 Employee reduction in hours
(remains as active part-time employee)
 Death of Employee date of death _____

The events listed below require employee's signature at bottom.

- Child's loss of dependent status Legal separation date _____
Reason _____ (Must provide Judicial Decree of Legal Separation)
 Employee's enrollment in Medicare Divorce Finalized on _____
(only covered dependents will be entitled to COBRA) (Provide current address above)

Events NOT QUALIFIED for COBRA or State Continuation Coverage (Reason must be given - check one only):

- Covered under another group¹ Unable to pay premium²
(Employee must sign waiver below) (Employee must sign waiver below)
 Termination of COBRA administered by employer

Termination Authorized / Requested By:

Signature of Company Representative (required) _____

Print Name _____ Title _____ Date _____

CERTIFICATION TO WAIVE/DECLINE COVERAGE

¹ I certify that I am waiving/declining coverage through the Benefit Plan for myself and/or my dependents listed above because I, and/or my dependents are covered under another employer-sponsored group coverage or have Medicare coverage. I understand that if my coverage or my dependent's coverage terminates, I may apply for coverage through the PIBT Plan and must do so within 30 days of termination of other coverage.

² I certify that I and/or my dependents listed above are eligible for coverage through the PIBT Plan and I decline coverage for myself and/or my dependents listed above. I understand that I cannot enroll myself and/or my dependents in any PIBT Plan until the next open enrollment period. (Dec-Jan).

Employee Signature (required) _____ Date: _____