Municipal Health Benefit Program

Termination Form

(for employee terminations only. If terminating dependents, please use Change form.)

Coverage Termination Date: _____

MHBP Use Only

Employee Information - All Fields Required Group Number: Group Name:

Employee First Name:	Employee Last Name:
Social Security Number:	Date of Birth:
Marital Status: Married / Single / Divorced (circle one)	Gender: Male / Female (circle one)
Full Mailing Address:	

Phone: (_____) _____ Email: _____

Reason for Termination:

☐Termination of employment: Last day of employment:_____

☐Reduction of hours: Effective date of reduction:_____

☐Employee Death: Date of death:_____

☐Medicare Eligible: Effective date of Medicare coverage:_____

☐Military Leave: Last day of work before Leave:_____ (copy of orders required)

☐Member Requests Termination: Effective date of cancellation:_____

Employee Signature: _____ **Date:** _____

(Employee signature not required for employment termination)

Group Rep. Signature: _____ **Date:** _____

MHBP use only

Eff 01.2022