



## COBRA Termination Request Form

Instructions: Please completely fill out this form to request for COBRA Termination. Incomplete, incorrect and/or illegible forms will be returned back to the sender and require a new form submission. Print and send completed form and send via email, fax or paper mail.

Email: [info@benstrat.com](mailto:info@benstrat.com)

Fax: (603) 232-6275

Benefit Strategies, LLC  
PO Box 3938  
Manchester, NH 03105-3938

### 1. Employee or Qualified COBRA Beneficiary (QB) Information:

Employee/QB Full Name: \_\_\_\_\_

Previous Employer Name: \_\_\_\_\_

Employee/QB last 4 of SSN: \_\_\_\_\_ (OR) Employee/QB Date of Birth: \_\_\_\_\_

Employee/QB Email: \_\_\_\_\_ Employee/QB Phone: \_\_\_\_\_

### 2. Benefit Termination Information:

Check off all boxes that apply to your request. We will only process 30 day retroactive termination requests.

	<b>Benefit</b>	<b>Effective Date</b>	<b>Terminate Coverage for ALL Covered</b>	<b>Name of Individual(s) to Terminate</b>
<input type="checkbox"/>	All Benefits		<input type="checkbox"/>	
<input type="checkbox"/>	Medical		<input type="checkbox"/>	
<input type="checkbox"/>	Dental		<input type="checkbox"/>	
<input type="checkbox"/>	Vision		<input type="checkbox"/>	
<input type="checkbox"/>	Other		<input type="checkbox"/>	
<b>*Reason</b>				

\*If termination is due to death, please provide a copy of the death certificate.

If termination is due to Medicare entitlement, please provide a copy of the Medicare card showing your Part B effective date IF ONLY dependent(s) are staying on COBRA.

I do not want to continue coverage for any dependents on my plan(s):

**3. Continuing Dependent(s) Coverage:**

ONLY if you wish to continue coverage for one or more of your dependent(s), please fill out the information below.

Full Name: \_\_\_\_\_ Relationship:  Spouse  Dependent Child  
Date of Birth: \_\_\_\_\_ Full SSN: \_\_\_\_\_  
Check off all that apply:  Medical  Dental  Vision  Other: \_\_\_\_\_

Full Name: \_\_\_\_\_ Relationship:  Spouse  Dependent Child  
Date of Birth: \_\_\_\_\_ Full SSN: \_\_\_\_\_  
Check off all that apply:  Medical  Dental  Vision  Other: \_\_\_\_\_

Full Name: \_\_\_\_\_ Relationship:  Spouse  Dependent Child  
Date of Birth: \_\_\_\_\_ Full SSN: \_\_\_\_\_  
Check off all that apply:  Medical  Dental  Vision  Other: \_\_\_\_\_

**4. Signature:**

*I understand this submission is a request to terminate my COBRA coverage for the specific benefit(s) indicated above. Any incomplete or illegible forms will be returned and I am required to submit a new form for completion of my request. I understand this process can take up to 14 business days and it is my responsibility to confirm with the insurance carrier(s) the termination(s) have been processed.*

Employee/QB Signature: \_\_\_\_\_ Date: \_\_\_\_\_