BlueCross BlueShield of Tennessee

801 Pine Street
Chattanooga, TN 37402-2555
www.bcbst.com

TERMINATION

PLEASE USE BLUE OR BLACK INK ONLY

Plan Use Only
Rec:______________

TRM

IF YOU PURCHASED COBRA ADMINISTRATION FROM BLUECROSS BLUESHIELD OF TENNESSEE, DO NOT COMPLETE THIS FORM. INSTEAD, COMPLETE THE COBRA COVERAGE CONTINUATION NOTICE (GB-108).

GROUP NO. | GROUP NAME | BLUECROSS BLUESHIELD OF TN BILLING ASSOCIATE

INSTRUCTIONS: Complete Section:
1 to terminate Employee / Elect Continuation Coverage
1 to terminate Employee and all Dependents / Elect Continuation Coverage for Employee and All Dependents
1 & 2 to terminate Employee / Elect Continuation Coverage for Some Dependents
2 to terminate Specific Dependents / Elect Continuation Coverage
If Employee wants COBRA / State Continuation at a later date, fill out Employee Enrollment / Waiver Form.

Section 1 – Employee Termination

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO: | TERMINATION DATE OF COVERAGE (M M D D Y Y)

COVERAGE TO TERMINATE: ☐ MEDICAL ☐ DENTAL ☐ LIFE
REASON: ☐ TERMINATION OF EMPLOYMENT ☐ REDUCTION IN HOURS ☐ NO LONGER ELIGIBLE EMPLOYEE ☐ DEATH ☐ MEDICARE ELIGIBLE ☐ OTHER

STATE CONTINUATION OF COVERAGE (Grps under 20): ☐ MEDICAL ☐ DENTAL
COBRA COVERAGE ELECTED: ☐ MEDICAL ☐ DENTAL
COBRA SUBGROUP | DEPARTMENT NO: | QUALIFYING EVENT DATE: (M M D D Y Y)

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO: | TERMINATION DATE OF COVERAGE (M M D D Y Y)

COVERAGE TO TERMINATE: ☐ MEDICAL ☐ DENTAL ☐ LIFE
REASON: ☐ TERMINATION OF EMPLOYMENT ☐ REDUCTION IN HOURS ☐ NO LONGER ELIGIBLE EMPLOYEE ☐ DEATH ☐ MEDICARE ELIGIBLE ☐ OTHER

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It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Completed by: ____________ Phone Number: ____________ Date: (M M D D Y Y)

Section 2 – Spouse / Dependent (s) Termination

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO: | TERMINATION DATE OF COVERAGE (M M D D Y Y)

☐ I WISH TO CHANGE TO INDIVIDUAL COVERAGE. APPLIES TO: ☐ MEDICAL ☐ DENTAL (DO NOT LIST SPOUSE / DEPENDENT(S))

☐ I WISH TO TERMINATE ONLY THE SPOUSE / DEPENDENT(S) LISTED BELOW.

DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | DEPENDENT SOCIAL SECURITY NO. | DATE OF BIRTH (M M D D Y Y Y Y) | TERMINATION DATE (M M D D Y Y)

COVERAGE TO TERMINATE
☐ MEDICAL ☐ DENTAL REASON: ☐ NO LONGER ELIGIBLE DEPENDENT ☐ DIVORCE ☐ MEDICARE ELIGIBLE ☐ DEATH OF DEPENDENT ☐ DEATH OF SUBSCRIBER OTHER

STATE CONTINUATION OF COVERAGE (Grps under 20)
☐ MEDICAL ☐ DENTAL

COBRA COVERAGE ELECTED
☐ MEDICAL ☐ DENTAL

COBRA SUBGROUP | DEPARTMENT NO: | QUALIFYING EVENT DATE (M M D D Y Y)

NEW ADDRESS FOR DEPENDENT

DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | DEPENDENT SOCIAL SECURITY NO. | DATE OF BIRTH (M M D D Y Y Y Y) | TERMINATION DATE (M M D D Y Y)

COVERAGE TO TERMINATE
☐ MEDICAL ☐ DENTAL REASON: ☐ NO LONGER ELIGIBLE DEPENDENT ☐ DIVORCE ☐ MEDICARE ELIGIBLE ☐ DEATH OF DEPENDENT ☐ DEATH OF SUBSCRIBER OTHER

STATE CONTINUATION OF COVERAGE (Grps under 20)
☐ MEDICAL ☐ DENTAL

COBRA COVERAGE ELECTED
☐ MEDICAL ☐ DENTAL

COBRA SUBGROUP | DEPARTMENT NO: | QUALIFYING EVENT DATE (M M D D Y Y)

NEW ADDRESS FOR DEPENDENT

EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | MI | IDENTIFICATION NO: | TERMINATION DATE OF COVERAGE (M M D D Y Y)

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COVERAGE TO TERMINATE
☐ MEDICAL ☐ DENTAL REASON: ☐ NO LONGER ELIGIBLE DEPENDENT ☐ DIVORCE ☐ MEDICARE ELIGIBLE ☐ DEATH OF DEPENDENT ☐ DEATH OF SUBSCRIBER OTHER

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