Request to Terminate COBRA Coverage – Benefit Eligible

Today's Date:_____

Participant's Name:_____

Participant's Social Security Number:_____

I would like to terminate the benefits selected below effective:_____
(Please note: Indicate last date of COBRA Coverage.)

Please indicate which benefits you would like to terminate by marking "DROP" in the boxes below.

	NAME	SSN	SIGNATURE REQUIRED IF OVER AGE 18	MEDICAL	DENTAL	VISION	FSA
PARTICIPANT				☐DROP	☐DROP	☐DROP	☐DROP
DEPENDENT 1				☐DROP	☐DROP	☐DROP	n/a
DEPENDENT 2				☐DROP	☐DROP	☐DROP	n/a
DEPENDENT 3				☐DROP	☐DROP	☐DROP	n/a
DEPENDENT 4				☐DROP	☐DROP	☐DROP	n/a

Reason for terminating benefits:

_____

_____

_____ _____

(Participant Signature) (Phone Number)

Please return to:
benefitexpress
1700 E. Golf Road, Suite 1000
Schaumburg, IL 60173
Phone: (877) 837-5017
Fax: (253) 793-3766

For internal use - Please confirm that you have notified the active administrator once COBRA coverage has been terminated. ☐ _____(Please initial and date)