MACo Health Care Trust
TERMINATION OF COVERAGE

USE A *MACoHCT ENROLLMENT & CHANGE FORM* TO DROP DEPENDENTS OR CHANGE THE STATUS OF AN ACTIVE EMPLOYEE TO RETIRED
PLEASE COMPLETE ALL SECTIONS OF THIS FORM IN BLUE OR BLACK INK

MEMBER GROUP/ EMPLOYER NAME:	
GROUP NUMBER:	
EMPLOYEE NAME:	
EMPLOYEE'S SOCIAL SECURITY NUMBER:	
EMPLOYEE'S LAST KNOWN ADDRESS:	
LAST DAY OF COVERAGE:	COVERAGE WILL AUTOMATICALLY END THE LAST DAY OF THE MONTH
REASON COVERAGE IS ENDING ⇩	CHECK APPROPRIATE BOX AND PROVIDE REQUESTED INFORMATION

- ☐ **INVOLUNTARY TERMINATION OF EMPLOYMENT** (EMPLOYEE LAID-OFF OR LET-GO)
  INDICATE LAST DAY OF EMPLOYMENT:
- ☐ **VOLUNTARY TERMINATION OF EMPLOYMENT** (EMPLOYEE WILLINGLY RESIGNED)
  INDICATE LAST DAY OF EMPLOYMENT:
- ☐ **REDUCTION IN HOURS WORKED TO LESS THAN 20 HOURS/WEEK**
  INDICATE LAST DAY EMPLOYEE WAS SCHEDULED TO WORK AT LEAST 20 HOURS/WEEK:
- ☐ **DROPPING COVERAGE AND STILL SCHEDULED TO WORK AT LEAST 20 HOUR/WEEK**
- ☐ **DROPPING COVERAGE DUE TO RETIREMENT** (AND RETIREE DOES NOT WISH TO REMAIN ENROLLED FOR COVERAGE)
  INDICATE EXACT DATE OF RETIREMENT:
- ☐ **DROPPING COVERAGE DUE TO OTHER INSURANCE COVERAGE OR MEDICARE ELIGIBILITY**
- ☐ **ACTIVE MILITARY SERVICE**
  INDICATE EXACT DATE EMPLOYEE BEGAN ACTIVE MILITARY SERVICE:
- ☐ **SOCIAL SECURITY DISABILITY**
  INDICATE EXACT DATE DISABILITY UNDER SOCIAL SECURITY BEGAN:
- ☐ **EMPLOYEE HAS NOT RESUMED WORKING AT LEAST 20 HOURS/WEEK FOLLOWING 12 WEEKS OF UNPAID LEAVE INCLUDING FMLA**
  INDICATE EXACT DATE THAT 12 WEEKS OF UNPAID LEAVE IS EXHAUSTED:
- ☐ **EMPLOYEE HAS NOT RESUMED WORKING AT LEAST 20 HOURS/WEEK FOLLOWING 12 WEEKS OF UNPAID LEAVE DUE TO A WORK COMP RELATED INJURY OR ILLNESS**
  INDICATE EXACT DATE THAT 12 WEEKS OF UNPAID WORK COMP LEAVE IS EXHAUSTED:
- ☐ **TEMPORARY LAYOFF**
  INDICATE EXACT DATE THAT TEMPORARY LAYOFF BEGAN:
- ☐ **EMPLOYEE DEATH**
  INDICATE DATE OF DEATH:
- ☐ **OTHER** (PLEASE EXPLAIN)

FORM COMPLETED BY:	**DATE:**

FOR MACoHCT USE ONLY	EFFECTIVE DATE OF TERMINATION:	COMPLETED BY: DATE COMPLETED:	NOTES:

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