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# COBRA Benefits Termination Form

This form is used to terminate one or more benefits.

If participating in ACH, please note Discovery Benefits needs to receive notification at least 15 days prior to the 1st of the month. If this form is received late, Discovery Benefits can't guarantee the ACH payment for that month will be canceled. However, if a payment is withdrawn, you will be refunded via check.

**IMPORTANT:** If applicable, any overpayment balance resulting from coverage termination will be refunded to the Primary Qualified Beneficiary unless otherwise indicated here:

☐ Apply to other benefits within the Primary Qualified Beneficiary account ☐ Apply to new account created due to coverage termination

*=Required Fields

## Step 1: Primary Qualified Beneficiary Information

*Primary Participant Name (First, MI, Last)

*Social Security Number

*Employer Sponsoring Benefits (Do not abbreviate)

*Day Telephone

Email Address

## Step 2: Completion Information

1. Enter the name(s) of the Person(s) Affected by the change. 2. Enter the Final Date of Coverage for each person listed. 3. Specify the Benefit(s) you are requesting to terminate. 4. If you wish to terminate Other Benefits, enter the name of those benefits. If you do not wish to terminate all benefits, specify below the benefits that should be terminated. Failure to complete Benefits and, if applicable, Other Benefits will result in the termination of all enrolled benefits.

Note: If you are enrolled in a Health FSA, Life Insurance and/or EAP and wish to terminate those benefits, be sure to identify which plans you would like terminated under Other Benefits.

| *Person(s) Affected | *Name (1) | *Final Date of Coverage (2) (mm/dd/yyyy) Most plans only allow end of month terminations | *Benefits (3) Coverage type must be checked | *Other Benefits (4) |
|---|---|---|---|---|
| Primary Qualified Beneficiary | | | ☐ Medical ☐ Dental ☐ Vision | |
| Spouse | | | ☐ Medical ☐ Dental ☐ Vision | |
| Dependent | | | ☐ Medical ☐ Dental ☐ Vision | |
| Dependent | | | ☐ Medical ☐ Dental ☐ Vision | |
| Dependent | | | ☐ Medical ☐ Dental ☐ Vision | |
| Dependent | | | ☐ Medical ☐ Dental ☐ Vision | |

If you are a COBRA participant, please use the COBRA Second Qualifying Event Form if the reason for requesting termination is due to death of the employee, divorce or legal separation from the employee or a dependent child ceasing to be a dependent.

## Step 3: Primary Qualified Beneficiary Certification

I understand my submission of this form is a request to terminate the specified benefit(s) indicated above. Further, I understand Discovery Benefits will contact me if my request to terminate coverage is denied for any reason.

*Primary Participant Signature

*Date

Spouse Signature (only required if coverage is being terminated for the spouse)

*Date

*C101*

*K502*