Lifetime BENEFIT SOLUTIONS

TERMINATION FORM

You have the right to request that we amend the Protected Health Information in the Designated Record Set we or our Business Associates maintain. We may decline your request if the information is not part of the Designated Record Set, we did not create the information, or we believe the information is complete and accurate. To exercise your right to request an amendment, please complete the following indicating the change requested.

Employee Name: _____ Social Security No: _____-____-_____

Address: _____ Union: ☐

_____ Non-Union: ☐

Type of Change:

EMPLOYEE

☐ Employee Termination (please see below):

Indicate Date and Reason:

Last Date of Coverage: ____/____/____

Last Date of Employment: ____/____/____

Employee Terminated ☐
Death ☐
Lay-Off ☐
COBRA Expiration ☐
Retirement ☐
Disability ☐

Send Cobra Notification ☐

____/____/____
DATE

____/____/____
DATE

DEPENDENT

☐ Dependent Termination (please see below):

Indicate Date and Reason:

Last Date of Coverage: ____/____/____

Dependent Name: _____

Relationship: _____

Employee Terminated ☐
Divorce ☐
Legal Separation ☐
Coverage Elsewhere ☐
Non-Student Status ☐
Dependent's Age ☐

Send Cobra Notification ☐

_____
EMPLOYEE SIGNATURE (IF APPLICABLE)

_____
HUMAN RESOURCE REPRESENTATIVE