ChurchHealth

MEMPHIS Plan
Participant Termination Notice
(*This form MUST be completed to terminate Participants*)

Today's Date: _____

Termination of: (Circle One) **Participant** **Dependent** **Both**

Name of Account: _____

Account Group Number: _____

Participant Name: _____

Participant Social Security #: _____

Dependent Coverage? (circle one) **Yes** **No**
Dependent Names: _____
_____
_____
_____

Termination Reason: (circle one)

Participant resignation
Participant dismissal
Cost of plan
Obtained other insurance
Obtained TennCare coverage
Pregnancy
Salary exceeds income limits
Works less than 20 hours/week
Death
Workforce Reduction
Other _____

Employer/Self Employed/MP Direct Signature: _____

DO NOT WRITE ON INVOICES.

- **THIS FORM MUST BE USED TO TERMINATE A PARTICIPANT.**
- **TERMINATIONS CANNOT BE CALLED IN,** YOU MUST FAX, E-MAIL or MAIL THIS SIGNED FORM to the MEMPHIS Plan office.
- A participant's coverage terminates the last day of the month this form arrives in the MEMPHIS Plan office; **NOT THE DATE THE PARTICIPANT WAS TERMINATED.**
- The Employer/Self Employed/MP Direct participant is responsible for the balance **until** THIS FORM ARRIVES IN the MEMPHIS Plan office.
- This form **must be received by the last day of the month** in order for it to be processed on your next invoice.
- **When a Participant's coverage is terminated, coverage for dependents is automatically terminated.**

Fax to MEMPHIS Plan office: (901) 278-6622
Mail to MEMPHIS Plan office: 1350 Concourse Ave., Ste. 142, Memphis, TN 38104
E-mail: MEMPHISPlan@churchhealth.org