

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 #:			<u></u>
Dependent Coverage? (circle of Dependent Names:		No	
Termination Reason: (circle of	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 Di	rect 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 <u>coverage terminates the last day of the month this form arrives in the MEMPHIS Plan office;</u> **NOT THE DATE THE PARTICIPANT WAS TERMINATED.**
- The Employer/Self Employed/MP Direct participant is responsible for the balance <u>until</u> 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