TICUA
BENEFIT CONSORTIUM

TERMINATION & COBRA FORM

Employees, please fill out this page, sign and date at the bottom, and return to your Human Resources department.

Section I: Employee Information					
Last Name	**First Name**	**MI**	**Social Security No.**	**College/University Name**	
			- -		
Home Address	**City**	**State**	**Zip**	**Phone Number**	
				( )	

Section II: Qualifying Beneficiary Information (If Other Than Employee)				
Last Name	**First Name**	**MI**	**Social Security No.**	**Relationship to Employee** (Spouse, son, etc.)
			- -	
Qualifying Event Date	**Effective Date Coverage Terminates**			

Section III: Qualifying Event (Choose One)

- ❑ Termination/Retirement other than gross misconduct (18 mo. COBRA period / 29 mo. For Social Security Disability)
- ❑ Death of Covered Employee (36 mo. COBRA period)
- ❑ Reduction in hours, includes Medical or Personal Leave of Absence, Suspension or Activated Military Reserve (18 mo. COBRA period/29 mo. for Social Security Disability)
- ❑ Divorce or legal separation: A copy of the Court Order page including the legal date of divorce or legal separation is required (36 mo. COBRA period)
- ❑ A dependent ceases to be a dependent as defined by the Employer's Group Plan (36 mo. COBRA period)
- ❑ Covered employee is entitled to Medicare (36 mo. COBRA period)
- ❑ Employer files for bankruptcy (Applies to retiree coverage only)

Section IV: Termination of Coverage Only -- If COBRA is NOT required, please check one of the following:

- ❑ Voluntarily dropping coverage
- ❑ Voluntarily dropping all spouse and/or dependent coverage
- ❑ Other group insurance without pre-existing conditions
- ❑ Retiring and entitled to Medicare with no spouse and/or dependents on current coverage, or spouse and/or dependents also entitled to Medicare
- ❑ Other (please explain): _____

Signature **DO NOT WRITE BELOW THIS LINE** **Date**

Employer, please fill in the information below and fax or mail to TICUA Benefit Consortium, 1031 17th Avenue South, Nashville, TN 37212 Tel. (615) 292-35352 Fax (615) 292-3933.

Group No.	Location No.	Employee's Effective Date of Coverage	**Employer: I certify that all the information included on this form is current and correct to the best of my knowledge.**			
			Signature		**Date**	

For Plan Administrators' Use Only

Date Received	Location	Birthdate	Gender	Hire Date	Effective Date	Date of Change	

Revised 2/15/2006