

Arena Technical Resources, LLC

Employee Medical and Dental Termination Form

Please print clearly in CAPITAL letters Please fill in completely Please sign the form

EMPLOYEE and DEPENDENT TERMINATION OF COVERAGE

Terminate active medical coverage

- Terminate employee and dependents
- Terminate spouse
- Terminate child(ren)

Terminate active dental coverage

- Terminate employee and dependents
- Terminate spouse
- Terminate child(ren)

REASON FOR TERMINATION

- Death of employee
 Loss of dependent status
 Employment status change
 End of employment
 Reduction in hours
 Enrollment in Medicare
 Dropping coverage voluntarily
 Gain of other coverage
 Court ordered cancellation
 Not eligible
 Non-payment of COBRA premium
 Other – specify: _____

TERMINATION DATES

Date of Termination Event: _____ Requested Effective Date of Termination: _____

TERMINATED EMPLOYEE AND DEPENDENT INFORMATION

Name (Last, First, Middle)	Relationship to Employee	Social Security Number	Birth Date MM/DD/YY	Gender M or F	> 18 & Full Time Student Yes or No	Disabled Yes or No

SIGNATURE AND VERIFICATION

EMPLOYEE SIGNATURE _____ **DATE** _____ **Note: Form invalid without both signatures**
EMPLOYER SIGNATURE/VERIFICATION _____ **DATE** _____