



# BENEFIT TERMINATION NOTICE

This form is to be used for a Qualifying  
**COBRA event for**  
**CITY OF GULFPORT EMPLOYEES**

City of Gulfport  
 1410 24th Avenue  
 Gulfport, MS 39501  
 228.868.5831 office  
 228.868.5833 fax

This BENEFIT TERMINATION NOTICE should be completed and returned to **City of Gulfport, 1410 24th Avenue, Gulfport, MS 39501** upon termination of coverage under your Medical Benefit Plan for any covered employee or dependent. This form will serve to terminate coverage and also to send appropriate COBRA Election Forms to the covered individual.

<b>EMPLOYEES LAST NAME</b>		<b>FIRST NAME</b>	<b>M.I.</b>	<b>SOCIAL SECURITY #</b>
<b>EMPLOYEE FILE #</b>	<b>EMPLOYEE'S PHONE #</b>	<b>SEX</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<b>MARITAL STATUS</b> <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED
<b>EMPLOYEE'S LAST KNOWN ADDRESS</b>			<b>CITY</b>	<b>STATE</b>
			<b>ZIP CODE</b>	

\*Note: If COBRA Notice should be mailed to an eligible dependent at an address that is different from the employee's address, please list addresses:

<b>REASON FOR TERMINATION OF COVERAGE:</b>	
<input type="checkbox"/> TERMINATION/RESIGNATION <input type="checkbox"/> REDUCED HOURS <input type="checkbox"/> DEATH OF EMPLOYEE <input type="checkbox"/> DIVORCE OR LEGAL SEPARATION <input type="checkbox"/> RETIREMENT	<input type="checkbox"/> INELIGIBLE DEPENDENT-Reason: _____ <input type="checkbox"/> MEDICARE ENTITLED _____ <input type="checkbox"/> DISABILITY _____ <input type="checkbox"/> OTHER _____ <input type="checkbox"/> GROSS MISCONDUCT*
*In the event of Gross Misconduct, covered employee will be notified that he or she is not eligible for COBRA continuation coverage.	
DATE ABOVE EVENT OCCURRED:	LAST DAY OF COVERAGE: _____ IS THIS A SECOND QUALIFYING EVENT FOR A DEPENDENT WHO IS CURRENTLY ON COBRA? <input type="checkbox"/> YES <input type="checkbox"/> NO

<b>PRESENT COVERAGE</b>		
<b>MEDICAL</b>	<b>DENTAL \$1500 or \$2000</b>	<b>VISION</b>
<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> INDIVIDUAL
<input type="checkbox"/> INDIVIDUAL AND SPOUSE	<input type="checkbox"/> INDIVIDUAL AND SPOUSE	<input type="checkbox"/> INDIVIDUAL AND SPOUSE
<input type="checkbox"/> INDIVIDUAL AND CHILDREN	<input type="checkbox"/> INDIVIDUAL AND CHILDREN	<input type="checkbox"/> INDIVIDUAL AND CHILDREN
<input type="checkbox"/> INDIVIDUAL AND FAMILY	<input type="checkbox"/> INDIVIDUAL AND FAMILY	<input type="checkbox"/> INDIVIDUAL AND FAMILY
Will the removal of the following person(s) allow a change in present coverage levels? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please write in the new coverage level for both Medical and Dental Coverage.		
Medical _____		Dental _____

<b>LIST ALL PERSONS ELIGIBLE FOR CONTINUATION COVERAGE: (MUST INCLUDE SOCIAL SECURITY NUMBER FOR ALL ELIGIBLE DEPENDENTS)</b>			
<b>LIST ONLY THOSE INDIVIDUALS FOR WHICH COVERAGE WILL BE TERMINATING.</b>			
<b>NAME</b>	<b>RELATIONSHIP TO EMPLOYEE</b>	<b>DATE OF BIRTH</b>	<b>SOCIAL SECURITY NUMBER</b>
(Address: If different from employee above)			
(Address: If different from employee above)			

**CITY OF GULFPORT**

EMPLOYER \_\_\_\_\_

#10609 \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_

SUBMITTED BY (EMPLOYEE SIGNATURE) \_\_\_\_\_

DATE \_\_\_\_\_

This section to be completed by Human Resources Department	Terminated Coverage – with S.A.S	_____	_____
		Initials	Date