

Benefit Plan Termination Form

To Delete a Dependent/Subscriber

Please print all information.

Department Use Only

Plan Code: _____ Term. Date: _____
 MED: _____ E-Class: _____
 VISION: _____ INITIALS: _____
 DENTAL: _____

No changes to your enrollment can be made during the plan year (January through December) without a qualifying family life status change. If you experience a qualifying event during the year, you may make changes to medical, dental, and FSA benefits within 30 days of the event. Any change you make must be consistent with your qualifying event. For example, you may terminate a spouse from your health insurance coverage following a divorce. **If you experience a change or qualifying event, you must provide documentation and written proof of notification to the Total Compensation and Wellness Department within 30 days of the qualifying event via interoffice mail or fax at (313) 577-0637.** The chart on page 36 lists supporting documentation required for each qualifying event. Documentation must be sent along with this form.

Subscriber Information *(If subscriber terminates all dependents terminate automatically. All fields required.)*

Social Security Number	Banner ID	E-mail Access ID	Last Name	First Name	Phone
------------------------	-----------	------------------	-----------	------------	-------

*Relation Code: S=Self/Employer, M=Spouse, C=Child, R=Senior Rider, O=Sponsored Dependent, H=Disabled Dependent, O=Other Eligible Person

1. Terminate Self* Cash In-Lieu Medical Vision Dental

Social Security Number	Last Name	First Name	Middle Name
Address and Street	Zip Code	City and State	Birth Date
Reason for deleting dependent (other coverage, divorce, loss of dependency, death, etc.)		Relation Code*	Date of event (divorce, other coverage, etc.)
Office Use Only: () SCOV () BCOV () SELG			

2. Terminate Dependent* Medical Vision Dental

Social Security Number	Last Name	First Name	Middle Name
Address and Street	Zip Code	City and State	Birth Date
Reason for deleting dependent (other coverage, divorce, loss of dependency, death, etc.) <i>Supporting documentation must be attached.</i>		Relation Code*	Date of event (divorce, other coverage, etc.)
Office Use Only: () SCOV () BCOV () SELG			

3. Terminate Dependent Medical Vision Dental

Social Security Number	Last Name	First Name	Middle Name
Address and Street	Zip Code	City and State	Birth Date
Reason for deleting dependent (other coverage, divorce, loss of dependency, death, etc.)		Relation Code*	Date of event (divorce, other coverage, etc.)
Office Use Only: () SCOV () BCOV () SELG			

The information listed above is correct to the best of my knowledge.

I understand that those terminated are eligible for COBRA under the provisions on page 8 of the Employee Benefit Handbook. I authorize release of the information listed above to the insurance plan I have selected for the purpose of eligibility information.

I have provided the required documentation to support proof of the above qualifying event(s).

Signature of Employee	Date Signed
-----------------------	-------------

*For additional dependents, use an additional form.