NORTH AMERICAN DIVISION BENEFITS
Health Care

HEALTH CARE EMPLOYEE BENEFITS TERMINATION REQUEST FORM

EMPLOYEE INSTRUCTIONS:
This form is to be completed only when terminating a spouse or child and to terminate an existing employee. This form may be completed by the employee, but must be signed by the employer before it is sent to Adventist Risk Management®, Inc. - Health Benefits Services.

EMPLOYEE INFORMATION:

NAME: SSN#

TERMINATIONS TO BE MADE: *Mark Choice* ☐ Termination Employee/Family ☐ Termination Spouse ☐ Child / Children

CHANGE DETAILS: (Fill in details for above marked choice)

LIST NAME OF EACH DEPENDANT OR SPOUSE TO BE TERMINATED

FIRST NAME	M.I.	LAST NAME	BIRTHDATE (MM/DD/YYYY)	Sex	DEPENDANT'S SSN#	OTHER INSURANCE YES / NO	OTHER INSURANCE PRIMARY / SECONDARY
				-		-	-
				-		-	-
				-		-	-
				-		-	-

OTHER INSURANCE NAME: PHONE#: EFFECTIVE DATE: (MM/DD/YYYY)

EMPLOYEE SIGNATURE: DATE SIGNED: (MM/DD/YYYY)

This form can be submitted electronically to: HEALTHCAREELIGIBILITY@adventistrisk.org
(You **must** save the document to your computer then attach it to the e-mail generated by the link above)

OFFICE USE ONLY

AUTHORIZED EMPLOYER'S SIGNATURE REQUIRED

EMPLOYER NAME	EFFECTIVE DATE (MM/DD/YYYY)	GROUP #	SUBGROUP #

RECEIVED ON:	
IBC	
TRANS#	
CARD	☐ IBC
CARD	☐ ARM
VERIFIED	☐ IBC ☐ WEB ☐ UCD ☐ RX
HIPPA CERT	

FOR ARM OFFICE USE ONLY

OFFICE USE ONLY

EMPLOYER SIGNATURE*: DATE (MM/DD/YYYY):

SIGNATORY'S NAME: COVERAGE CODE:

SIGNATORY'S TITLE:

***Please enter your initials to serve as your digital signature.**
By entering your initials and sending this form attached to an e-mail from your e-mail account, we will consider this form signed by you.