



TERMINATION NOTIFICATION FORM

Please list below all employees for whom you have **DELETED PAYMENT** on this month's billing, giving the reason for termination of coverage (see list), date of event and current address. **Return this form to the Health Trust with your monthly bill when you remit your Premium.**

List Date of Last ACTIVE Day of Work		EMPLOYER USE ONLY		FOR MMEHT USE ONLY		
		Employee's Name & Mailing Address		Dependents' Names		Life Vol.
Code:	Date:	Employee		Employee End Date		EE
		ID#:		Dep 1		SP
If term code is "C", check all boxes that apply.	Health	Life	Address		Dep 2	
	IPP	Dental	City/State		Dep 3	
	Vision	LTD			Dep 4	
Code:	Date:	Employee		Employee End Date		EE
		ID#:		Dep 1		SP
If term code is "C", check all boxes that apply.	Health	Life	Address		Dep 2	
	IPP	Dental	City/State		Dep 3	
	Vision	LTD			Dep 4	
Code:	Date:	Employee		Employee End Date		EE
		ID#:		Dep 1		SP
If term code is "C", check all boxes that apply.	Health	Life	Address		Dep 2	
	IPP	Dental	City/State		Dep 3	
	Vision	LTD			Dep 4	

Reason for Coverage Termination:	
T Involuntary Termination	H Reduction of Hours making them ineligible for coverage
V Voluntary Resignation	M Retirement – Withdrawing from MPERS
L Temporary Layoff	R Retirement – Not withdrawing from MPERS
A Leave of Absence	W Work Related Injury or Occupational Disease
C Cancellation Requested	X Active Employee chooses Medicare & cancels HT
D Death of the Employee - Note Date of Death	F Military
E Disability	

Municipality/Employer Name

Signature of Person Completing