

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.**

LETTER CODE/ REASON FOR CVG. TERMINATION & LAST DATE ACTIVELY AT WORK		EMPLOYER USE ONLY		FOR MMEHT USE ONLY			
		Employee's Name & Mailing Address		Dependents' Names		Start Dates	Life Vol.
CODE:	Date:	Employee		Employee End Date			EE
		ID#:		Dep 1			SP
		Address		Dep 2			DEP
		City/State		Dep 3			DEP
		Name2		Dep 4			
CODE:	Date:	Employee		Employee End Date			EE
		ID#:		Dep 1			SP
		Address		Dep 2			DEP
		City/State		Dep 3			DEP
		Name2		Dep 4			
CODE:	Date:	Employee		Employee End Date			EE
		ID#:		Dep 1			SP
		Address		Dep 2			DEP
		City/State		Dep 3			DEP
		Name2		Dep 4			

Reason for Coverage Termination:

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

Municipality/District

Person Completing