

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:

- | | |
|---|--|
| <ul style="list-style-type: none"> T Involuntary Termination V Voluntary Resignation L Temporary Layoff A Leave of Absence C Cancellation Requested D Death of the Employee - Note Date of Death E Disability | <ul style="list-style-type: none"> H Reduction of Hours making them ineligible for coverage M Retirement – Withdrawing from MPERS R Retirement – Not withdrawing from MPERS W Work Related Injury or Occupational Disease X Active Employee chooses Medicare & cancels HT F Military |
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Municipality/Employer Name

Person Completing