Reset Form

OPEH&W Health Plan
www.opehw.com

Plan Termination Notice

Member SSN

To be submitted for all Employees and/or Dependents whose coverage is terminating.
You must submit this completed form to the Plan Administrators office immediately.

Prepared By

Title

Employer Group Name

Date Prepared

Dependent's SSN (only if it is not the Member whose coverage is terminating)

The following information pertains to the individual who's coverage is terminating

Last Name

First Name Middle Initial

Date of Birth!

Please verify the **last known** good mailing address for this individual!Address

Mailing Address

City, State & Zip

Primary Phone

Date event occurred or will occur

Date event was reported to you

Plan termination date (last day of the month in which health plan coverage is to be terminated)

Reason for termination of coverage (Select One)

M Member Only Options
S Spouse Only Options
D Dependent Only Options

- M ☐ Voluntary Termination of Employment/Resignation (if Retiring, see below)
- M ☐ Involuntary Termination of Employment (i.e. Laid Off, Misconduct, Etc.)
- M ☐ Involuntary Termination of Employment (due to Gross Misconduct)
- M ☐ No longer meets eligibility rules (i.e. Reduction of Hours)
- S ☐ Divorce
- S ☐ Legal Separation
- M ☐ FMLA Exhausted
- M ☐ Leave of Absence
- M ☐ Workman's Comp
- ☐ Death
- D ☐ No longer a legal dependent
- D ☐ Over 26 (& not permanently disabled)
- M ☐ Retiring - Must be able to check one of the following eligibility criteria:

  ☐ **A.** Member is vested with one of the following Oklahoma public employee retirement programs:
  ☐ OTRS ☐ OPERS ☐ OLERS ☐ OkMRF ☐ Other_____

  ☐ **B.** The sum of the Member's age plus their years of service (starting with their employment date) equals at least the number 80 when they retire.

Other Remarks (Optional)

Send this form to your designated Health Plan Specialist via secure email or secure FAX

OPEH&W Health Plan Administration Office Use Only

Date Received Date Processed Processed By