



Termination Form

**Form must be completed entirely for all terminations including life only.
Please submit via secure email to Illinois School Insurance Network**

mwil.isinadministration@marshmma.com

Employee Information	
District Name: <u>Laraway School District 70C</u>	Social Security #: <u> — —</u>
Employee Name: _____	Date of Birth: <u> / /</u>
Address: _____	Telephone #: <u> — —</u>
City, State, Zip: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F

Event Date: _____	<i>NOTE: Coverage will terminate at the end of the month in which the termination event occurs.</i>
Reason for Termination:	<input type="checkbox"/> Left Employment <input type="checkbox"/> Death <input type="checkbox"/> Involuntary Termination <input type="checkbox"/> Retirement <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Ineligible child <input type="checkbox"/> Eligible for Other Coverage <input type="checkbox"/> Other Describe: _____

List Individuals Terminating from Coverage (include employee if terming)

Name	Social Security #	Birth Date	Gender	Relationship
	— —	/ /		
	— —	/ /		
	— —	/ /		
	— —	/ /		
	— —	/ /		

Current Benefits - Terminate Coverage for:

Plan	Coverage	Plan	Notes
Medical Insurance BCBS of IL	<input type="checkbox"/> Single	<input type="checkbox"/> B14332 HMO BA Plan 3	
	<input type="checkbox"/> Empl + 1	<input type="checkbox"/> B01776 HMO BA Plan 4	
	<input type="checkbox"/> Family	<input type="checkbox"/> 165609 Executive PPO	
		<input type="checkbox"/> 165608 Standard PPO	
		<input type="checkbox"/> 165607 Standard PPO	
		<input type="checkbox"/> 165602 HDHP	
		<input type="checkbox"/> No coverage	
	Dental Insurance BCBS of IL	<input type="checkbox"/> Single	<input type="checkbox"/> 270729 DPPO 1500
<input type="checkbox"/> Empl +1		<input type="checkbox"/> 270736 DPPO 2000	
<input type="checkbox"/> Family		<input type="checkbox"/> No coverage	
Vision Insurance VSP	<input type="checkbox"/> Single	<input type="checkbox"/> 12019596 Vision Plan 175	
	<input type="checkbox"/> Empl +1	<input type="checkbox"/> No coverage	
	<input type="checkbox"/> Family		

Terminate Life Insurance: Yes No Last FSA Deduction: _____ N/A

Completed by: _____ Date: _____ / _____ / _____