NORTH AMERICAN DIVISION BENEFITS

Health Care

HEALTH CARE EMPLOYEE E
TERMINATION REQUEST

EMPLOYEE INSTRUCTIONS:
This form is to be completed only when terminating a spouse or child and to terminate an existing employee. This form may be completed by the em
it is sent to Adventist Risk Management®, Inc. - Health Bene ts Services.

EMPLOYEE INFORMATION:

NAME: SSN#

TERMINATIONS TO BE MADE: Mark Termination Termination Employee/Family Termination Spouse Child / Children

CHANGE DETAIL: (Fill in details for above marked choice)

LIST NAME OF EACH DEPENDANT OR SPOUSE TO BE TERMINATED

FIRST NAME	M.I.	LAST NAME	BIRTHDATE (MM/DD/YYYY)	Sex	DEPENDANT'S SSN#	OTHER INSURANCE YES / NO	PRIMARY / SECONDARY

OTHER INSURANCE NAME: PHONE#: EFFECTIVE DATE: (MM/DD/YYYY)

EMPLOYEE SIGNATURE: DATE SIGNED: (MM/DD/YYYY)

This form can be submitted electronically to: HEALTHCAREELIGIBILITY@adventistrisk.org
(You must save the document to your computer then attach it to the e-mail generated by the link above)

OFFICE USE ONLY

AUTHORIZED EMPLOYER'S SIGNATURE REQUIRED

EMPLOYER NAME	EFFECTIVE DATE (MM/DD/YYYY)	GROUP #	SUBGROUP #

RECEIVED ON:

IBC				
TRANS#				
CARD	IBC			
CARD	ARM			
VERIFIED	IBC	WEB	UCD	RX
HIPPA CERT				

FOR ARM OFFICE USE ONLY

OFFICE USE ONLY

EMPLOYER SIGNATURE*: DATE MM/DD/YYYY :

SIGNATORY'S NAME: COVERAGE CODE:

SIGNATORY'S TITLE:

*Please enter your initials to serve as your digital signature.
By entering your initials and sending this form attached to an e-mail from your e-mail account, we will consider this form signed by