Multiple Employee/Member Termination Form

From (Name of Employer Group)	Submitted by (Signature)	Telephone Number
	X	( ) -

HMO Group Number	Traditional Control Number	Print Name of Authorized Employer Representative	Date

First and Last Name	**Social Security Number**	**Member ID Number**	**Effective Date of Termination**	**Termination Reason Code.** (See below.)	**CSA**	**Comments (optional)**
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

TERMINATION CODES: C=Changed Health Plan, D=Death, DIS=Disability, L=Layoff, M=Medicare, R=Resignation, RH=Reduction in Hours, S=Student Status Change, T=Termination, DI=Divorce or Legal Separation, N=Nonpayment

If unable to determine the reason for the termination, use “T”.

*** NOTE:** If an employee and entire family are being terminated from the plan, it is only necessary to list the employee information on the form for termination.

Please make a copy for your records.