

**TERMINATION FORM**

You have the right to request that we amend the Protected Health Information in the Designated Record Set we or our Business Associates maintain. We may decline your request if the information is not part of the Designated Record Set, we did not create the information, or we believe the information is complete and accurate. To exercise your right to request an amendment, please complete the following indicating the change requested.

Employee Name: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Address: \_\_\_\_\_ Union:   
 \_\_\_\_\_ Non-Union:

**Type of Change:**

**EMPLOYEE**

Employee Termination (please see below):

**Indicate Date and Reason:**

Last Date of Coverage: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Date of Employment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee Terminated

Death

Lay-Off

COBRA Expiration

Retirement

Disability

Send Cobra Notification

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE

**DEPENDENT**

Dependent Termination (please see below):

**Indicate Date and Reason:**

Last Date of Coverage: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dependent Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Employee Terminated

Divorce

Legal Separation

Coverage Elsewhere

Non-Student Status

Dependent's Age

Send Cobra Notification

\_\_\_\_\_  
EMPLOYEE SIGNATURE (IF APPLICABLE)

\_\_\_\_\_  
HUMAN RESOURCE REPRESENTATIVE