Markel Basic Health Insurance Termination Report

Complete this form to cancel coverage on employees and dependents when they are no longer eligible for coverage. All other changes (request a change in coverage, adding a dependent, etc.) require an Enrollment Form to be completed.

Sponsor's Number: _______________ Today's Date: ___________________

Employer's Name: _______________ Billing Period: ___________________

Employer's Address: ______________ Contact Name: __________________

____________ ______________ Telephone Number: ______________

State Zip

Employee's Name (Last, First, MI)	Social Security Number	Term Code *(List name of dependent for Codes 2 & 4)	Termination Date

*Reasons for Termination

1. Employment Terminated
2. Deceased
3. Non-Payment of Premium (COBRA/Continuation
4. Loss of Eligibility – (List the name of the dependent who is no longer eligible).

Mail completed form to:

Co-ordinated Benefit Plans
PO Box 21282, Tampa, FL 33632-1282
Phone: 877-794-6917