



Multiple Employee/Member Termination Form

From (Name of Employer Group)	Submitted by (Signature) X	Telephone Number () -
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HMO Group Number	Traditional Control Number	Print Name of Authorized Employer Representative	Date
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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.