INDECS
A HOMESTEAD COMPANY
1099 Wall Street West
Suite 317
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Fax (201) 460-3204

TERMINATION

OU Health

Use only when all coverage, or any part of existing coverage, is to be terminated.

Last Name | First Name | MI | Social Security No.

CHECK THE APPROPRIATE SECTION

ENTER THE EFFECTIVE DATE

Section 1

TERMINATION OF COVERAGE

(Use Only when ALL Coverage is to Terminate)

Effective Date

Employment Termination Due to Gross Misconduct

Coverage Termination Reason:

Section 2

DELETION OF COVERAGE

(Use Only to Terminate a Portion of Existing Coverage)

Effective Date

Delete Family Coverage; Change to Individual Reason:

Delete one or more Dependents. Furnish complete information on EACH Dependent to be deleted.
Indicate relationships as son, daughter, or other. *(If other, detail in remarks.)*

		First Name	MI	Last Name (if different)	Date of Birth	Effective Date
1.	Spouse M F					
2.	Dep M F					
3.	Dep M F					
4.	Dep M F					

Remarks: *(Refer to Persons 1-4 above.)*

Reason for Deletion. *(Refer to Persons 1-4 above.)*

1. 2. 3. 4.

Section 3

MISCELLANEOUS

Detail any Termination/Deletion not covered by this form, or use this area to clarify any of the above changed information.

AUTHORIZATION/CERTIFICATION

I understand that the Plans and coverages listed above shall be in effect until revoked or changed by me in writing. I certify that the information completed above is true and accurate, knowing that falsified or fraudulent disclosures are punishable by law.

Enrollee's Signature: ______________________________ Date

LOCAL ADMINISTRATORS - MUST BE COMPLETED

Enrollee's Hire Date: Coverage Effective Date:

I certify that I have the original of this document, signed by the Enrollee, which will be maintained by this District. Current Date

Print Name Signature