Western Health Advantage

Termination Form

Directions: Complete the entire form to report member terminations to your account.

Employer	Group no.
Contact name	
Phone	
Signature	
Date submitted	

MEMBER NAME (employee or dependent's name)	**MEMBER ID**	**TERMINATION DATE**	**TERMINATION REASON** — see below*

* **TERMINATION REASONS —** Please use to indicate the reason for termination in the table above.

1. Voluntary termination of employment
2. Involuntary termination of employment
3. Open enrollment/changed insurance carrier
4. Reduction of hours
5. Retired
6. Member deceased
7. Dependent ceasing to be eligible due to age
8. Dependent ceasing to be eligible due to divorce
9. Voluntary termination of dependent coverage
10. COBRA — voluntary termination
11. COBRA — non-payment of premium
12. COBRA — limit reached
13. Error — member never eligible
14. Other (explain):_____

_____

_____

For Employers with 2–19 eligible employees: WHA must be notified within 30 days of any members' loss of coverage in order to properly administer Group Health Continuation Coverage (Cal-COBRA) to those members. A termination date and reason must be provided. *If WHA is not notified within 30 days, WHA will not be liable to offer Cal-COBRA to those members.*

Fax form to:
916.568.0334

2349 Gateway Oaks Drive
Suite 100
Sacramento, CA 95833

916.563.2250 or
888.563.2250

Visit our website for more information at:
westernhealth.com