



# COBRA Termination Form

## 1. Qualified Beneficiary Information

Name (First, Middle Initial, Last)

Requested Termination Effective Date

 -  - 

Social Security Number

## 2. Primary Qualified Beneficiary Authorization

Signature

Date

By signing above I understand that my COBRA continuation coverage will terminate on the requested effective date unless my premiums paid have not been paid in full to the requested date. I also understand that any Electronic Debit Payments will stop on the requested effective date.