Discovery Benefits
FSA • HSA • HRA • COBRA • Transportation

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COBRA Benefits Termination Form

This form is to terminate one or more benefits continued through COBRA.

If participating in ACH, please note Discovery Benefits needs to receive notification at least 15 days prior to the 1st of the month of your requested termination. If this form is received after that timeframe, Discovery Benefits cannot guarantee that the ACH payment for that month will be cancelled. However, if a payment is withdrawn, you will be refunded via check.

Step 1: Primary Qualified Beneficiary Information

*=Required Fields

*Primary Qualified Beneficiary Name (First, MI, Last)

*Social Security Number ___ - __ - ____

*Previous Employer (Do not abbreviate)

*Day Telephone ___ - ___ - ____

Email Address

Step 2: Benefit Termination Information

Please specify the benefit(s) you are requesting to discontinue through COBRA. Please also indicate the effective date you are requesting coverage to terminate as well as the person(s) affected by the change.

	*Benefits	*Effective Dates of Termination (mm/dd/yyyy)	*Person(s) Affected (PQB and/or Dependents)
	Medical		
	Dental		
	Vision		
	Other (__________________)		
	Other (__________________)		
	Other (__________________)		

If the reason for requesting termination is due to death of the former employee, divorce or legal separation from the former employee, or a dependent child's ceasing to be a dependent, please use the **COBRA Second Qualifying Event Form**.

Step 3: Primary Qualified Beneficiary Certification

I understand my submission of this form is a request to terminate the specified benefit(s) indicated above. Further, I understand Discovery Benefits will contact me if my request to terminate coverage is denied for any reason.

*Primary Qualified Beneficiary Signature

*Date