Arizona Public Employers Health Pool
TERMINATION OF EMPLOYMENT/BENEFITS FORM

Employer: _____

TERMINATION REASON (EMPLOYEE ONLY)

Last day worked (date) _____ **, 20** _____

Please check reason for termination:

- ☐ Termination/Layoff/Retirement
- ☐ Reduction in Hours so Ineligible for Benefits
- ☐ Medicare or Medicaid Entitlement
- ☐ Voluntary Termination of Benefits
- ☐ Gross Misconduct
- ☐ Death of Employee without Dependents
- ☐ Death of Employee with Dependents
- ☐ Administrative Error
- ☐ New Retiree
- ☐ USERRA Military Leave

☐ Other (explain)

MEMBERSHIP INFORMATION

Employee Last Name	First Name	Middle Initial

Mailing Address	Social Security #

City	State	Zip

Gender	Date of Birth (Month/Day/Year)	Daytime Phone Number	Marital Status
☐ Male ☐ Female			☐ S ☐ M ☐ D ☐ W

ENROLLMENT INFORMATION

☐ Core Plan ☐ Copay Plan ☐ HDHP ($1,500 Deductible) ☐ HDHP ($2,500 Deductible) ☐ HDHP ($5,000 Deductible)

☐ Member only	☐ Vision Member only	☐ Dental Member only
☐ Member & Spouse/Domestic Partner	☐ Vision for Spouse/Domestic Partner	☐ Dental for Spouse/Domestic Partner
☐ Member & Children	☐ Vision for Self & Children	☐ Dental for Self & Children
☐ Member & Family	☐ Vision for Self & Family	☐ Dental for Self & Family

	Additional Life Amounts	Premiums per Month
Employee	_____	$ _____
Spouse	_____	$ _____
Child	_____	$ _____

FOR HR USE ONLY – DO NOT WRITE BELOW THIS LINE

Coverage Cancellation Date: _____

Employer Signature: X _____ **Date:** _____