COBRA Benefits Termination

Surency COBRA

This form is to terminate one or more benefits. Please use the COBRA Second Qualifying Event form if the reason for requesting termination is due to the death of the employee, divorce or legal separation from the employee, or a dependent child ceasing to be a dependent.

If participating in ACH, Surency needs to receive notification at least 15 days prior to the 1st of the month. If this form is received late, Surency can't guarantee the ACH payment for that month will be cancelled. However, if a payment is withdrawn, you will be refunded via check.

Step 1: Primary Qualifed Beneficiary Information

Name (First, MI, Last): _____

Social Security Number: _____ Phone Number: _____

Email: _____

Employer Sponsoring Benefits: _____

Step 2: Termination Information

Please provide the specific benefits that should be terminated in the table below. If you wish to terminate benefits not listed, enter the name of those specific benefits under the ***Other Benefits*** section.
Failure to complete the ***Benefits*** section and, if applicable, the ***Other Benefits*** section will result in the termination of all enrolled benefits.

Person(s) Affected	Name	Final Date of Coverage (MM/DD/YYYY)	Benefits	Other Benefits
Primary Qualified Beneficiary			☐ Medical ☐ Vision ☐ Dental	
Spouse			☐ Medical ☐ Vision ☐ Dental	
Dependent			☐ Medical ☐ Vision ☐ Dental	
Dependent			☐ Medical ☐ Vision ☐ Dental	
Dependent			☐ Medical ☐ Vision ☐ Dental	
Dependent			☐ Medical ☐ Vision ☐ Dental	

Important: If applicable, any overpayment balance resulting from coverage termination will be refunded to the Primary Qualified Beneficiary unless otherwise indicated here.

☐ Apply to other benefits within the Primary Qualified Beneficiary account

☐ Apply to new account created due to coverage termination

Step 3: Qualified Beneficiary Certification

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

Primary Participant Signature: _____ Date: _____

Spouse Signature: _____ Date: _____
(Only required if coverage is being terminated for the spouse.)

Return completed form back to Surency at email: cobra@surency.com - fax: 316-272-4842

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