WAUGH AGENCY INSURANCE

TERMINATION REQUEST

In order to process your termination request **please c**omplete the information below**:**

Company Name: _____

Employee Name: _____

DOB, Last 4 of SSN, or Member ID#(s) _____

Date of Termination (last day of active coverage): _____

Carrier(s) / Plan(s) Name(s): _____

_____

Notes: _____

_____

Reason for Termination:

- ☐ No longer employed
- ☐ Employee now covered by spouse
- ☐ Employee no longer eligible (full-time to part-time)
- ☐ Other; please specify _____

_____ Authorized Company Representative Signature

_____ Title

_____ Printed Name of Company Rep

_____ Date

_____ Phone Number of Company Rep

Please fax or secure email the completed form to: (**800**) **779-4090** or **service@waughagency.com**