WAUGH AGENCY INSURANCE

Termination Request

Group Benefits · Coverage Termination

In order to process your termination request, please complete the information below.

All fields are required. Use Tab to move between fields.

◆ 01 · EMPLOYER

Company

Company Name

◆ 02 · EMPLOYEE

Employee to Terminate

Employee Name

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

◆ 03 · COVERAGE

Termination Details

Date of Termination (last day of active coverage)

Carrier(s) / Plan(s) Name(s)

◆ 04 · REASON

Reason for Termination

- ☐ No longer employed
- ☐ Voluntary
- ☐ Involuntary
- ☐ Gross misconduct
- ☐ Employee now covered by spouse
- ☐ Employee no longer eligible (full-time to part-time)
- ☐ Other — please specify:

◆ 05 · NOTES — ADDITIONAL INFORMATION

◆ 06 · AUTHORIZATION

Company Representative

Authorized Company Representative Signature

Title

Printed Name of Company Rep

Date (MM/DD/YYYY)

Phone Number of Company Rep

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

300 Brickstone Square, Suite 201, Unit 237 · Andover, MA 01810

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