

STATE OF NEBRASKA

COBRA/RETIREE TERMINATION FORM

MUST BE COMPLETED BY THE AGENCY PERSONNEL OFFICE AND SENT TO PERSONNEL, HEALTH & LIFE BENEFITS SECTION WITHIN 14 DAYS OF TERMINATION.

EMPLOYEE NAME (LAST, FIRST, M.I.)		SOCIAL SECURITY NUMBER and Employee ID NUMBER	
ADDRESS		CITY, STATE, ZIP	
DATE OF BIRTH/AGE (65 or older see #13)	Gender	AGENCY NAME	
DATE OF QUALIFYING EVENT		DATE COVERAGE WILL TERMINATE	
DATE COVERAGE BEGAN		DATE OF HIRE	
*FULL NAME (LAST, FIRST, M.I.)	SOCIAL SECURITY NUMBER	Gender	DATE OF BIRTH
SPOUSE'S NAME			
DEPENDENT'S NAME			
DEPENDENT'S NAME			
DEPENDENT'S NAME			

**LIST ADDITIONAL DEPENDENTS ON BACK. If Dependent mailing address is different, please note on back of form.*

Reason for termination of coverage (Qualifying Event); please MARK one:

1. Voluntary termination of employment (If Yes, is the employee paying into the Retirement System Yes or No).
2. Involuntary termination (If Yes, is the employee paying into the Retirement System Yes or No).
3. Reduction in work hours (less than 1/2 time) OR LEAVE OF ABSENCE.
4. Death of Employee.
5. Legal separation or divorce (legal separation as granted by a judge; or completion of six month waiting period for divorce).
6. Dependent child ceasing to be eligible dependent (we have to have dependent's SS# to process)
Turning 26 _____; Other _____
7. Retirement.
8. Leaving State Government due to a disability.
9. Open Enrollment Change from one health plan to another.
10. Open Enrollment Period for spouse.
11. Active Military Leave.
12. **Employee is 65 years of age or older.**

Circle one: Employee is Monthly or Biweekly

INSURANCE CARRIER	TYPE OF COVERAGE	LIFE/LTD/LTC CODES
<input type="checkbox"/> United Health Care Choice	<input type="checkbox"/> Single	
<input type="checkbox"/> United Health Care Wellness	<input type="checkbox"/> 2 Party Employee and Spouse	
<input type="checkbox"/> United Health Care Regular	<input type="checkbox"/> 4 Party Employee and Child(ren)	
<input type="checkbox"/> United Health Care High Deductible	<input type="checkbox"/> Family	

AMERITAS DENTAL (check correct plan)

Basic Single 2-Party 4-Party Family
Premium Single 2-Party 4-Party Family

EYEMED VISION (check correct plan)

Basic Single 2-Party 4-Party Family
Premium Single 2-Party 4-Party Family

EAP: YES or NO (circle one)

Flexible Spending, List Dollar Amounts –

Medical → _____ Dependent → _____

Agency: _____ Agency Representative: _____

Telephone Number: _____ Date: _____