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.)	**Employee ID NUMBER**
ADDRESS	**CITY, STATE, ZIP**
AGENCY NAME	
DATE OF QUALIFYING EVENT	**DATE COVERAGE WILL TERMINATE**
***FULL NAME (LAST, FIRST, M.I.)**	
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)
Dependent child ceasing to be eligible dependent (**we have to have dependent's SS# to process**)
6 ☐ 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.**

Employee is ☐ Monthly or ☐ Biweekly

INSURANCE CARRIER	TYPE OF COVERAGE	LIFE/LTD/LTC CODES
☐ Consumer Focused Health Plan	☐ Single	
☐ Wellness Health Plan	☐ 2 Party Employee and Spouse	
☐ Regular Health Plan	☐ 4 Party Employee and Child(ren)	
☐ High Deductible Health Plan	☐ Family	

AMERITAS DENTAL (check correct plan)

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

VISION COVERAGE (check correct plan)

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

Flexible Spending, list Dollar Amounts - _____

EAP: YES ☐ or NO ☐ **Medical →** _____ **Dependent →** _____

Agency: _____ **Agency Representative:** _____

Telephone Number: _____ **Date:** _____

Questions on completing this form or clarification of any section of this form should be addressed to
Terri Wilson in State Employee Wellness and Benefits at (402) 471-4107 or Email terri.wilson@nebraska.gov

Revised 7/10/2014