CaliforniaChoice
Your Health. Your Choice.

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# Termination of Employment/ Employee Reduction in Hours Notification

**Company Name**

**CaliforniaChoice Group #** 0

**If employment has been terminated for any covered employee, or an employee has deceased, complete the following, including date* of last active day at work. If any covered employee had a reduction of hours, complete the following, including date* of last day eligible.**

**1**

**Employee Last Name** | **Employee First Name**

**Employee Social Security Number** | ***Last Day Worked or Date Hours Reduced** (mo/day/year) | **Reason:**
- ◯ *Employment terminated*
- ◯ *Hours reduced, no longer eligible*
- ◯ *Deceased*

**2**

**Employee Last Name** | **Employee First Name**

**Employee Social Security Number** | ***Last Day Worked or Date Hours Reduced** (mo/day/year) | **Reason:**
- ◯ *Employment terminated*
- ◯ *Hours reduced, no longer eligible*
- ◯ *Deceased*

**3**

**Employee Last Name** | **Employee First Name**

**Employee Social Security Number** | ***Last Day Worked or Date Hours Reduced** (mo/day/year) | **Reason:**
- ◯ *Employment terminated*
- ◯ *Hours reduced, no longer eligible*
- ◯ *Deceased*

**4**

**Employee Last Name** | **Employee First Name**

**Employee Social Security Number** | ***Last Day Worked or Date Hours Reduced** (mo/day/year) | **Reason:**
- ◯ *Employment terminated*
- ◯ *Hours reduced, no longer eligible*
- ◯ *Deceased*

**Note: Voluntary withdrawals of employees and/or dependents must be submitted on a Change Request form and will be effective the end of the month in which the request is received.**

***Please do not send this request for termination prior to the actual last day worked or last day eligible. Coverage will cease at the end of the month following the last day worked or date hours reduced.***

***CaliforniaChoice will not credit retroactively beyond three (3) billed invoices.***

Please terminate health insurance coverage for the above referenced employee(s):

Group Plan Administrator Signature

Date

Print Name

**This documentation may be faxed or mailed to California*Choice*.**