NOTIFICATION OF TERMINATION FOR HEALTH BENEFITS - SATELLITE AGENCIES

It is extremely important that this form is completed and faxed to the Employee Benefits Division in a timely manner. This form is essential to ensure that non-covered employees and dependents do not receive State health benefits. Efforts will be made to collect premiums for employees and dependents that are no longer eligible for the State's health benefits.

TO: Office of Personnel Services and Benefits
Employee Benefits Division

FROM: _____
Agency Appointing Authority/Designee

PLEASE REMOVE THIS EMPLOYEE FROM YOUR RECORDS

Name:_____ Social Security Number:_____

Agency Code: _____ Date of Birth:_____

Effective Date of Termination:_____

Check one box in the column below:

Termination Reason

- ☐ Terminated
- ☐ Resigned
- ☐ Deceased – Date: _____
- ☐ Retired – Date: _____

Employee Type

- ☐ Satellite

APPROVAL:

_____ _____
Print Name of Appointing Authority/Designee Date

_____ _____
Signature of Appointing Authority/Designee Date

FAX THIS FORM TO: (410) 333-5191

Agency FAX#_____ Agency PHONE#_____

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