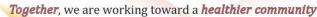


Health Benefits





NOTIFICATION OF TERMINATION OF EMPLOYEE BENEFITS SATELLITE AGENCIES

Complete and email this form to the Employee Benefits in a timely manner following termination resignation or death to terminate coverage.

- Coverage terminates on the last day of the month coincident with or following termination
- Premium is due and payable for members that are not terminated in a timely manner
- Email: Satellite.ebd@Maryland.gov

TO: Employee Benefits Division – Participant Servi	ces
FROM: Agency Appointing Authority/Designee	Phone:
Agency Appointing Authority/Designee	
The following employee is no longer employed and sh	ould be removed from our Benefit Plans
Name:	SSN:
Agency Code:	DOB:
Last Day on Payroll:	Date of Termination:
Reason Terminated	
☐ Resignation	
□ Deceased – Date	
Print Name / Appointing Authority/Designee	Email
Signature / Appointing Authority/Designee	 Date