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 Services

FROM: _____ Phone: _____
Agency Appointing Authority/Designee

The following employee is no longer employed and should 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