NOTIFICATION OF TERMINATION FOR HEALTH BENEFITS

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 subsidized benefits. Efforts will be made to collect State subsidized premiums for employees and dependents that are no longer eligible for the State subsidized benefits.

NOTE: **Please do not send a Notice of Termination form for an employee who is transferring to another State of Maryland agency.**

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 and Check Distribution Code:__________________Date of Birth:_______________

*For University of MD, indicate check distribution code:*____________________________________

Last day on payroll (last day worked):____

Check one box in each of the following columns:

Termination Reason

- ☐ Terminated
- ☐ Resigned
- ☐ Deceased – Date: _____________
- ☐ Retired – Date: _______________

Employee Type

- ☐ Active
- ☐ Contractual

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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