Avera Health Plans

TO BE COMPLETED BY EMPLOYER

Employer Name: _____

Group Number: _____

Termination of Coverage Form

Employer is to complete this form to terminate coverage for an employee and/or the employee's dependents. See Page 2 for more information.

EMPLOYEE INFORMATION

Subscriber Last Name: _____ First Name: _____

Subscriber Number or Social Security Number: _____

Address: _____ Phone: (_____) _____- _____

City: _____ State: _____ ZIP: _____ County: _____

QUALIFYING EVENT (Continuation Coverage)

Coverage (check all that apply): ☐ Medical Plan ☐ Dental Plan ☐ Vision Plan

Coverage Effective Date: _____ Qualifying Event Date: _____ Last Day of Coverage: _____ COBRA Begin Date: _____

EMPLOYEE

☐ Termination of Employment
- ☐ Lay-off
- ☐ Medical Leave of Absence
- ☐ Non-Medical Leave of Absence
- ☐ Other, Explain: _____

☐ Reduction in Hours (Full-time to Part-time)

DEPENDENT

☐ Death of Covered Employee

☐ Employee's Entitlement to Medicare
- ➢Did the employee term employment or have reduction in hours? ☐ Yes ☐ No

☐ Child's Loss of Dependent Status

☐ Divorce, please attach copy of divorce decree or ex-spouse's signature below.*

☐ Other, Explain:_____ _____

List Dependents: _____

_____

VOLUNTARY TERMINATION OF SUBSCRIBER AND/OR DEPENDENT(S) COVERAGE

Coverage (check all that apply): ☐ Medical Plan ☐ Dental Plan ☐ Vision Plan

Last day of coverage: _____

☐ Termination of Subscriber Coverage ☐ Termination of Dependent(s) Coverage (List names below.)

List Dependent(s): _____

Reason (check one): ☐ Other Coverage ☐ Terminating Coverage Voluntarily (still employed) ☐ Other: _____

NOTE: Avera Health Plans ***requires*** the signed consent from the subscriber and dependent spouse* for any voluntary termination of coverage.

I understand that the termination date with Avera Health Plans will be the last day of the month in which termination was requested or the last day of the month in which this form is received by Avera Health Plans, whichever is later.

Employee Signature: _____ Date: _____

I, the undersigned, hereby give my informed consent to be terminated from dependent spouse coverage under Avera Health Plans.

***Spouse Signature**: _____ Date: _____

EMPLOYER INFORMATION The following must be completed by an authorized employer group representative.

Name/Completed By *(please print):* _____ Phone: _____ Date: _____

Employer Signature: _____ Email: _____

Please fax completed form to (605) 322-4689 or mail to: Avera Health Plans, Enrollment Dept.
3816 S. Elmwood Ave., Suite 100
Sioux Falls, SD 57105-6538

If any questions, please call our Service Center at (605) 322-4545 or toll-free 1 (888) 322-2115, 8 a.m. to 5 p.m. CT, Monday through Friday.

Instructions for Completing the Termination of Coverage Form

Use this form to terminate coverage for an employee or an employee's dependents.

EMPLOYEE INFORMATION SECTION

Complete this section with the employee's information as requested.

QUALIFYING EVENT SECTION

To Be Completed by the Employer: Complete this section if the employee is terminating coverage or a dependent is terminating coverage *and* there is a qualifying event for continuation coverage. It is important that all requested fields are completed so that we can administer continuation coverage rights accordingly.

Coverage Effective Date: Enter the original effective date of coverage.

Qualifying Event Date: Enter the date on which the qualifying event occurred. For example, if the event is *Termination of Employment*, the qualifying event date would be the last day that the employee worked, although coverage may extend through the end of that month. The qualifying event date is required for the administration of continuation coverage.

Last Day of Coverage: Enter the date on which the employer-paid coverage ceases. For example, an employee may leave employment on Oct. 15 (the qualifying date) and be covered through the end of the month, Oct. 31. Therefore, Oct. 31, would be the last day of coverage.

COBRA Begin Date: This is the first day of the COBRA continuation period. In most cases, the COBRA begin date is the first day of the month following the date of the qualifying event. For example, the qualifying event date is Oct. 15. The last day of coverage would be Oct.31. Therefore, COBRA coverage begins Nov. 1.

Sometimes there may be contractual arrangements where an employee's coverage is paid for a period of time by the employer and this paid portion is not included in the COBRA continuation period.

VOLUNTARY TERMINATION OF SUBSCRIBER AND/OR DEPENDENT(S) COVERAGE SECTION

Employer Requirements: Complete this section if an employee or the employee's dependent(s) ***voluntarily*** requests to cancel their coverage. A voluntary cancellation of coverage does not constitute a qualifying event for continuation coverage. Check all applicable boxes and note date of cancellation.

Avera Health Plans must be notified in writing prior to the date to end coverage for any voluntary terminations. Cancellation will take place on the last day of the month in which the termination was requested or the last day of the month in which this Termination of Coverage Form was received by Avera Health Plans, whichever is later.

Employee Requirements: To voluntarily cancel coverage for the employee or the employee's dependents, the employee's signature is required.

Spouse's Signature Requirements: If the covered, dependent spouse requests to voluntarily cancel coverage, the signature of the spouse is required.

EMPLOYER INFORMATION SECTION

An authorized employer representative is required to sign and complete this section to authorize Avera Health Plans to process any termination of coverage request.

Avera Health Plans

Discrimination is Against the Law

Avera Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Avera Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Avera Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the Avera Health Plans Service Center at 1-888-322-2115, (TTY 711), 8 a.m. to 5 p.m. CST, Monday through Friday.

If you believe that Avera Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Complaint and Appeals Coordinator
Avera Health Plans
3816 S. Elmwood, Suite 100,
Sioux Falls, SD 57105-6538

Fax 1-800-269-8561
Email ComplaintAppeals@AveraHealthPlans.com

You can file a grievance in person or by mail, fax, or email. You may also contact the Complaint and Appeals Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or call 1-800-368-1019 or 1-800-537-7697 (TDD). Or mail:

US Department of Health and Human Services,
200 Independence Avenue SW Room 509F, HHH Building,
Washington, D.C. 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Avera Health Plans

Getting Help in other Languages

Language assistance services are available free of charge. Our Service Center is available 8 a.m. to 5 p.m. CST, Monday – Friday, toll-free at 1-888-322-2115 (TTY: 1-800-877-1113).

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-322-2115 (TTY: 1-800-877-1113).
- US CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-322-2115 (TTY: 1-800-877-1113).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-322-2115 (TTY: 1-800-877-1113).
- XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-322-2115 (TTY: 1-800-877-1113).
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-322-2115 (TTY: 1-800-877-1113).
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-322-2115 (TTY: 1-800-877-1113).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-322-2115 (телетайп: (TTY: 1-800-877-1113).
- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-322-2115 (رقم هاتف الصم والبكم: 1-800-877-1113.
- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-322-2115 (TTY: 1-800-877-1113).
- ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဃိ. နမၤနဲ့ ကျိာ်အတ်မၤစၢၤလၢ တလာ်ဘူဉ်လာ်စ့ၢၤ နီတမံၤဘဉ်သ့နူဉ်လီၤ. ကိး:1-888-322-2115 (TTY: 1-800-877-1113).
- ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-322-2115 (TTY: 1-800-877-1113).
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-322-2115 (TTY: 1-800-877-1113) 번으로 전화해 주십시오.
- ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-322-2115 (መስማት ለተሳናቸው: 1-800-877-1113)
- OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-322-2115 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-877-1113)
- ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-322-2115 (TTY: 1-800-877-1113)។