



Termination Form

Form must be completed entirely for all terminations including life only.
Please submit via secure email to Illinois School Insurance Network
mwil.isinadministration@marshmma.com

Employee Information	
District Name: <u>Lockport Elementary SD 91</u>	Social Security #: <u> — —</u>
Employee Name: _____	Date of Birth: <u> / /</u>
Address: _____	Telephone #: <u> — —</u>
City, State, Zip: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F

Event Date: _____	<u> / /</u>
<i>NOTE: Coverage will terminate at the end of the month in which the termination event occurs.</i>	

Reason for Termination:	<input type="checkbox"/> Left Employment <input type="checkbox"/> Death <input type="checkbox"/> Involuntary Termination <input type="checkbox"/> Retirement <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Ineligible child <input type="checkbox"/> Eligible for Other Coverage <input type="checkbox"/> Other Describe: _____
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List Individuals Terminating from Coverage (include employee if terming)

Name	Social Security #	Birth Date	Gender	Relationship
	— —	/ /		
	— —	/ /		
	— —	/ /		
	— —	/ /		
	— —	/ /		

Current Benefits - Terminate Coverage for:

Plan	Coverage	Plan	Notes
Medical Insurance BCBS of IL	<input type="checkbox"/> Single	<input type="checkbox"/> HMO BA Plan 2 B03881	
	<input type="checkbox"/> Empl + 1	<input type="checkbox"/> HMO BA Plan 3 B14332	
	<input type="checkbox"/> Family	<input type="checkbox"/> HMO BA Plan 4 B01776	
		<input type="checkbox"/> PPO 165611	
		<input type="checkbox"/> No coverage	
Dental Insurance BCBS of Illinois or Guardian <i>Guardian is a Non-Affiliation benefit—not administered by LAA. District contact responsible for administration.</i>	<input type="checkbox"/> Single	<input type="checkbox"/> Guardian—00378495 DHMO	
	<input type="checkbox"/> Empl + 1	<input type="checkbox"/> Guardian—00378495 DPPO	
		<input type="checkbox"/> BCBS of Illinois—270728 DPPO 1000	
	<input type="checkbox"/> Family	<input type="checkbox"/> BCBS of Illinois—270729 DPPO 1500	
		<input type="checkbox"/> BCBS of Illinois—D14330 DHMO	
		<input type="checkbox"/> No coverage	
Vision Insurance VSP	<input type="checkbox"/> Single	<input type="checkbox"/> Vision Plan 175 12019596	
	<input type="checkbox"/> Empl + 1	No coverage	
	<input type="checkbox"/> Family		

Terminate Life Insurance: Yes No Last FSA Deduction: _____ N/A

Completed by: _____ Date: / /