



Employee Healthcare Termination Form

Today's Date: _____

Company Name: _____

Employee Name: _____

Termination of Employment

Reason _____

Date _____

Voluntary Termination of Benefits

Benefits to cancel _____

Reason _____

Requested Term Date* _____

Employee Signature _____

*In most cases, coverage cannot be terminated mid-month

Comments: _____

**Please send to GMS
Attn: Katie
kkuczinski@gbsohio.com
Fax: (330) 659-0194**

GMS Office Use Only

Scorpeo _____
Carrier (Med) _____
Carrier (Den) _____
Carrier (Vis) _____
Carrier (Other) _____

COBRA _____
Rates for COBRA
Medical _____ → _____
Dental _____ → _____
Vision _____ → _____