



1099 Wall Street West, Lyndhurst, NJ 07071  
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 Form #OUSD-4510E-8/15

**TERMINATION**



Use only when all coverage, or any part of existing coverage, is to be terminated.

ENROLLEE'S SCHOOL DISTRICT:

**TYPE:** Last Name  First Name  Initial  SSN

CHECK THE APPROPRIATE SECTION

ENTER THE EFFECTIVE DATE

**Section 1**

**TERMINATION OF COVERAGE**

*(Use Only When ALL Coverage is to Terminate.)*

- Employment Termination Due to Gross Misconduct. Effective Date
- Coverage Termination Reason:  Effective Date

**Section 2**

**DELETION OF COVERAGE**

*(Use Only to Terminate a Portion of Existing Coverage.)*

- Delete Family Coverage; Change to Individual Reason:  Effective Date
- Delete one or more dependents. Furnish complete information on EACH dependent to be deleted. Indicate relationships as son, daughter, or other. *(If other, detail in remarks.)* Effective Date

	Spouse	First Name	M	Last Name (If different)	Sex	Date of Birth	Effective Date
1.	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
2.	Dependent	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
3.	Dependent	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
4.	Dependent	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>

Remarks: *(Refer to Persons 1-4 above.)*

Reason for Deletion. *(Refer to Persons 1-4 above.)*

1.  2.  3.  4.

**Section 3**

**MISCELLANEOUS**

Detail any termination/deletion not covered by this form, or use this area to clarify any of the above changed information.

**AUTHORIZATION/CERTIFICATION**

I authorize the above coverage terminations or deletions and understand that any resulting plan or coverage changes will be in effect until revoked or changed by me in writing. I certify that the information completed above is true and accurate, knowing that falsified or fraudulent information is punishable by law.

Enrollee's Signature: \_\_\_\_\_ Date

**LOCAL ADMINISTRATORS - (MUST BE COMPLETED)**

A. Is the reason for termination/deletion a COBRA qualifying event?  Yes  No

B. If "Yes" to (A), address where extension notice is to be mailed *(refer to persons (1) through (4) listed in Section 2):*

Dependent #  Street Address  City  State  Zip Code

Print Name  Signature  Current Date