FirstCarolinaCare
INSURANCE COMPANY

MEMBER TERMINATION NOTIFICATION

EMPLOYER NAME: _____ **GROUP NUMBER**: _____

DATE OF NOTICE: _____ **DATE OF QUALIFYING EVENT:** _____ **BENEFIT TERM DATE:** _____

EMPLOYEE NAME: _____
(FIRST) (MI) (LAST)

EMPLOYEE ADDRESS _____
STREET ADDRESS CITY STATE ZIP

EMPLOYEE SSN: _____

BIRTH DATE: _____ GENDER: _____

MEDICAL TIER LEVEL DENTAL TIER LEVEL (if no dental, leave blank)

_____ _____

MEMBERS EFFECTIVE DATE ON PLAN: _____

DEPENDENTS COVERED	DATE OF BIRTH
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

QUALIFYING EVENT CAUSING LOSS OF COVERAGE (Check one)

O Employee Termination of Employment (18 months)

O Employee's Reduction of Hours (18 months)

O Death of Employee (36 months)

O Divorce / Legal Separation (36 months)

O Employee becomes entitled to Medicare (36 months)

O Ineligibility of Dependant Child (36 months)

SIGNATURE

I AGREE THAT THE ABOVE INFORMATION IS CORRECT.

PREPARED BY: _____ TELEPHONE _____

SIGNATURE: _____ DATE: _____

INSTRUCTIONS

FAX completed form to **(910) 715-8101** to the attention of **Enrollment Department**.

You may also mail the completed form to:

Enrollment Department
FirstCarolinaCare Insurance Company
42 Memorial Drive
Pinehurst, NC 28374

If you have any questions, please call Member Services at (910) 715-8100 or toll free at (800)-574-8556.

INTERNAL USE ONLY

DATE RECEIVED: _____ DATE MAILED: _____ TRAVIS COBRA _____ DST AUDITED _____