Termination Form

www.hcgaz.com • 602.417.6755 • 800.247.2289 (outside Maricopa County)
701 E. Jefferson St. • MD 1400 • Phoenix, AZ 85034

A State-Sponsored Health Plan

Type:	**Reason:**	**Requested Date of Term:**	**Today's Date:**
❏ Business/Group ❏ Employee ❏ Dependent	❏ Do Not Wish to Renew ❏ Business Moved Out of State ❏ Going out of Business/Sold Business ❏ Employment Termination ❏ No Longer Self Employed ❏ Reduction of Hours (fewer than 20 hrs per week) ❏ Over 19 yrs Old and Not Enrolled in School ❏ Dependent Hired as an Employee ❏ Divorce from the Subscriber ❏ Death of the Subscriber ❏ Enrollment in Spouse's Group Coverage ❏ Enrollment in a Government Health Plan (Medicare, Medicaid) ❏ Other ______________________	*Date must be 30 days from receipt date. Please see list of qualifying reasons/events (left) as stated in the GSA.*	

SECTION A

Business Name ______________________ DBA Name ______________________

HCG Group Number __________ Business Owner Name ______________ 2nd Authorized Contact ______________

Business Mailing Address ______________________ City ______________ State ______ Zip Code ________

Business Physical Address ______________________ City ______________ State ______ Zip Code ________

Phone ______________ Fax ______________ E-mail Address ______________________

SECTION B

❏ Employee ❏ Dependent(s) Only

Employee/Dependent Name ______________________ Member ID ______________________

Additional Dependent Name ______________________ Additional Dependent Name ______________________

Additional Dependent Name ______________________ Additional Dependent Name ______________________

Home Phone Number ______________________ Work Phone Number ______________________

Employee Home Address ______________________ City ______________________

County ______________ State ______ Zip Code ________ E-mail Address ______________________

SECTION C Instructions

How to Terminate a Member: The Employee can only terminate mid-contract year if a qualifying event has occurred. The Employer shall notify HCGA in writing, provide the required forms and submit proof of meeting the qualifying event above following the timelines outlined below. No voluntary termination is allowed during the Group's contract year.

Timelines: The Employees' coverage will be terminated effective 11:59 pm on the last day of the month in which the Employer provides written notice via this form of employee termination to HCG. If termination notice is received after the month of Employee termination, the enrollment will not be retroactively terminated; it will terminate the last day of the month in which written notification is received. Premium for the Employee continues to be owed until the last day of the month in which written notification is received.

How to Terminate a Group: The Employer Group can only terminate mid-contract year if a qualifying event has occurred. The Employer Group shall notify HCGA in writing, provide the required forms and submit proof of meeting the qualifying event above following the timelines outlined below. No voluntary termination is allowed during the Group's contract year.

Timelines: The Group may terminate its coverage for a qualifying event following the receipt of a thirty (30) day written notification via this form to HCGA. The termination of coverage will be effective at 11:59 on the last day of the month following the thirty (30) day notification.

Employee Signature (also required for dependents) ______________________ **Date** ________
(not required for group termination or if employment has been terminated)

Employer/Authorized Contact Signature ______________________ **Date** ________

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