

# Cancellation/Qualifying Event for Continuation

You may fax this form to (574) 537-6642.

## Part A – To be completed by the employer

Group name \_\_\_\_\_

Name of employee \_\_\_\_\_

Agreement number \_\_\_\_\_

Current address \_\_\_\_\_

Street

City

State

ZIP

Social Security number \_\_\_\_\_

If you are canceling an employee, please complete Part B. We will cancel all the employee's participating family members unless you instruct us otherwise. You need to notify Everence within 30 days after coverage ends due to the qualifying event. If dental or vision coverage is provided by a carrier other than Everence, you need to notify the carrier of all individuals being canceled.

If an employee is canceling a participating family member, he or she will need to complete Part C.

## Part B – To be completed by the employer if you are canceling an employee and his or her participating dependents

Last day actively at work \_\_\_\_\_ Loss of coverage date \_\_\_\_\_

If the reason for cancellation is a qualifying event for continuation, please select one:

Loss of coverage due to termination of employment

Voluntary  Involuntary

Reduction in hours to ineligible status

Death

Medicare entitlement

Date of qualifying event \_\_\_\_\_

If the reason for cancellation is not a qualifying event for continuation, please give the reason.

\_\_\_\_\_  
Date of cancellation \_\_\_\_\_

Coverage currently enrolled in:

Medical

Dental

Vision

FlexChoice

\_\_\_\_\_  
Signature of group representative

\_\_\_\_\_  
Date

**Part C – To be completed by the employee if canceling a participating family member**

If you are maintaining your health coverage with the group plan, but canceling a family member's coverage, you need to notify Everence within 60 days after coverage ends due to the qualifying event.

Person(s) to be canceled from all current plans:

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

Address (if different than indicated in Part A above):

\_\_\_\_\_

Street \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

If the reason for cancellation is a qualifying event for continuation, please select one:

- Divorce/legal separation
- Dependent no longer meets eligibility requirements

Date of qualifying event \_\_\_\_\_

If the reason for cancellation is not a qualifying event for continuation, please give the reason.

\_\_\_\_\_

Date of cancellation \_\_\_\_\_

\_\_\_\_\_  
Signature of employee

\_\_\_\_\_  
Date

**Everence Insurance Company**  
1110 North Main Street      Toll-free: (800) 348-7468  
Post Office Box 483        T: (574) 533-9511  
Goshen, IN 46527  
www.everence.com