NORTH CAROLINA
BAR ASSOCIATION
HEALTH BENEFIT TRUST

TO BE COMPLETED BY GROUP ADMINISTRATOR

Group Number: _____

Effective Date: _____

CANCELLATION OF COVERAGE FORM

For those **remaining employed** who would like to cancel coverage.

EMPLOYEE NAME:	SOCIAL SECURITY NUMBER:
EMPLOYER/FIRM NAME:	REQUESTED EFFECTIVE DATE:

☐ I am canceling employee coverage.

☐ I am canceling spouse coverage.

☐ I am canceling dependent coverage.

I am canceling coverage for the following reason:

_____

In the case of divorce, separation, death, marriage of dependent or age limit, please give date of occurrence: _____

Names of spouse/dependents to be cancelled from this group plan:

_____

_____

I understand that if I elect to apply for coverage for myself, my spouse and/or my dependent children through this employer health benefit plan at a later time, the enrollment will be dependent on the qualifying event status of the effected participants.

Signature of Employee: _____ Date: _____

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