



# Arizona Public Employers Health Pool

## TERMINATION OF EMPLOYMENT/BENEFITS FORM

Employer: \_\_\_\_\_

**TERMINATION REASON  
(EMPLOYEE ONLY)**

Termination of employment (date) \_\_\_\_\_, 20\_\_\_\_\_

**Please check reason for termination:**

- |  |   |
|--|---|
| <input type="checkbox"/> Termination/Layoff/Retirement                 | <input type="checkbox"/> Death of Employee without Dependents |
| <input type="checkbox"/> Reduction in Hours so Ineligible for Benefits | <input type="checkbox"/> Death of Employee with Dependents    |
| <input type="checkbox"/> Medicare or Medicaid Entitlement              | <input type="checkbox"/> Administrative Error                 |
| <input type="checkbox"/> Voluntary Termination of Benefits             | <input type="checkbox"/> New Retiree                          |
| <input type="checkbox"/> Gross Misconduct                              | <input type="checkbox"/> USERRA Military Leave                |

Other (explain) \_\_\_\_\_

\_\_\_\_\_

**MEMBERSHIP INFORMATION**

Employee Last Name		First Name		Middle Initial
Mailing Address			Social Security #	
City			State	Zip
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year)	Daytime Phone Number		Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W

**ENROLLMENT INFORMATION**

Core Plan     Copay Plan     Core Plus Plan     HDHP (\$1,500 Deductible)     HDHP (\$2,500 Deductible)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Employee only                      | <input type="checkbox"/> Vision Employee only               | <input type="checkbox"/> Dental Employee only               |
| <input type="checkbox"/> Employee & Spouse/Domestic Partner | <input type="checkbox"/> Vision for Spouse/Domestic Partner | <input type="checkbox"/> Dental for Spouse/Domestic Partner |
| <input type="checkbox"/> Employee & Children                | <input type="checkbox"/> Vision for Self & Children         | <input type="checkbox"/> Dental for Self & Children         |
| <input type="checkbox"/> Employee & Family                  | <input type="checkbox"/> Vision for Self & Family           | <input type="checkbox"/> Dental for Self & Family           |

<input type="checkbox"/> Retiree only <input type="checkbox"/> Retiree & Spouse/Domestic Partner <input type="checkbox"/> Retiree & Children <input type="checkbox"/> Retiree & Family	Additional Life Amounts Employee _____ Spouse _____ Child _____	Premiums per Month \$ _____ \$ _____ \$ _____
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**FOR HR USE ONLY – DO NOT WRITE BELOW THIS LINE**

Date of Hire: \_\_\_\_\_ Coverage Effective Date: \_\_\_\_\_

Employer Signature: \_\_\_\_\_ Date: \_\_\_\_\_