Termination Form

FOR GROUPS

Western Health Advantage

Mail to: 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Send it by secure fax to: 916.568.0334
Update online: eBill on westernhealth.com
Direct Inquiries: 916.563.2250 or 888.563.2250

FOR EMPLOYER USE Complete the entire form to report member termination to your account

Employer _____ **Group #** _____

Contact Name _____ **Phone** _____

Signature _____ **Date** _____

MEMBER INFORMATION Provide all information requested for each employee and/or dependent to be terminated from account

Member Full Name (employee or dependent)	**Member ID**	**Termination Date**	**Termination Reason*** (see below)

***TERMINATION REASON** Use the following number code to indicate reason for termination in the table above

1. Voluntary termination of employment
2. Involuntary termination of employment
3. Open enrollment/changed insurance carrier
4. Reduction of hours
5. Retired
6. Member deceased
7. Dependent ceasing to be eligible due to age
8. Dependent ceasing to be eligible due to divorce
9. Voluntary termination of dependent coverage
10. COBRA — voluntary termination
11. COBRA — non-payment of premium
12. COBRA — limit reached
13. Error — member never eligible
14. Other (explain): _____

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FOR EMPLOYERS WITH 2–19 ELIGIBLE EMPLOYEES: WHA must be notified within 30 days of any members' loss of coverage in order to properly administer Group Health Continuation Coverage (Cal-COBRA) to those members. A termination date and reason must be provided. If WHA is not notified within 30 days, WHA will not be liable to offer Cal-COBRA to those members.