



COX HEALTH PLANS

CoxHealth

Cox Health Systems HMO, Inc
Cox Health Systems Insurance Company

P.O. Box 5750 - Springfield MO 65801-5750 - Phone 417-269-2900 Fax 417-269-2801

Termination Notice

The Employer shall notify Cox Health Plans, Inc., in writing whenever any Member ceases to be eligible for coverage no later than thirty (30) days after the event that rendered the Member ineligible for coverage. The Employer will be liable to pay premiums on behalf of any Member for whom the required notice of ineligibility has not been given.

The following information is submitted to remove this employee from the health benefit plan.

Company Name

Group #

Terminating Employee

Social Security Number

Date of Termination of Employment

Member ID #

Date of Termination of Coverage

Signature of Employee if still eligible

Signature of Company Administrator

Date

FEDERAL CONTINUATION OF COVERAGE (COBRA) If a Member is a qualified beneficiary entitled to elect continuation of coverage under the terms of the Consolidated Omnibus Budget Reconciliation Act the Employer must notify Cox Health Systems HMO of the Members election to continue coverage on the COBRA Notification and Application form with a newly completed enrollment form. Cox HealthPlans, Inc., must receive notice from the Employer for termination of the continuation coverage or of any qualifying event that may allow a COBRA participant an extended service period.