

Intermountain District Church of the Nazarene  
**EMPLOYEE'S REQUEST TO TERMINATE INSURANCE**

(must be filed a minimum of ten days prior to effective termination date)

Employee's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

The undersigned hereby authorizes termination of insurance coverage for the following qualified beneficiary (check one):

- Employee                       Spouse                       Family  
 Dependent (name only those terminating) \_\_\_\_\_

through the Intermountain District Church of the Nazarene's group insurance plan(s) as checked below:

- Regence Blue Shield                       Delta Dental

The undersigned requests coverage be terminated effective \_\_\_\_\_ for the following reason:

- Death of Insured                       Legal Separation or Divorce  
 Reduction in Work Hours                       Child No Longer an Eligible Dependent  
 Insured's Employment Terminated (for reasons other than gross misconduct)  
 Electing cover under spouse's group \_\_\_\_\_ health and/or \_\_\_\_\_ dental plan  
 Electing coverage under self-purchased \_\_\_\_\_ health and/or \_\_\_\_\_ dental plan

Employee's Signature: \_\_\_\_\_ Dated: \_\_\_\_\_



**QUALIFIED BENEFICIARY'S NOTIFICATION OF COBRA INTENT**

(complete and sign *ONLY ONE* of the sections below)

\_\_\_\_\_ The undersigned **ELECTS** to continue coverage under COBRA with:  Regence Blue Shield       Delta Dental

List all persons for whom continuation of coverage is elected (use back of form for additional names/SSNs/DOBs):

Name (First, MI, Last)	Social Security No.	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please give the complete address where invoices and statements for the monthly COBRA premiums are to be sent:

\_\_\_\_\_

Qualified Beneficiary's Signature: \_\_\_\_\_ Dated: \_\_\_\_\_



\_\_\_\_\_ The undersigned **DECLINES** coverage under COBRA with:  Regence Blue Shield       Delta Dental

Qualified Beneficiary's Signature: \_\_\_\_\_ Dated: \_\_\_\_\_