

Cancellation Request

Mennonite Church USA

Return the completed form to TPA Services, Everence Association Inc., PO Box 483, Goshen, IN 46527, or fax to (574) 537-6642.

Part A – To be completed by the group representative

Before completing this request, you will need to discuss the continuation option available to canceling eligible plan participants.

Note: An individual who is enrolled in or eligible to enroll in Medicare is not eligible for continuation coverage.

Employer _____

Employee _____

Birthdate _____

Current address _____
Street City State ZIP

If you are canceling an employee due to an employment-related event, please complete Part B. We will cancel all the employee's participating family members unless you instruct us otherwise. You need to notify Everence within 30 days after coverage ends due to the cancellation event.

If an employee is canceling a participating family member, he or she will need to complete Part C.

Part B – To be completed by the employer if you are canceling an employee and his or her participating dependents due to an employment-related event

Last day actively at work _____ Date of cancellation event* _____

Reason for cancellation:

Loss of coverage due to termination of employment

Voluntary Involuntary

Reduction in hours to ineligible status

Exhaustion of FMLA leave

Death

Medicare enrollment as primary coverage

Other _____

Coverage currently enrolled in (check all that apply):

CEP health

FlexChoice

Dental

Long-term disability

Vision

Life/accidental death and dismemberment

Special Instructions _____

Signature of group representative

Date

Part C – To be completed by the employee if canceling a participating family member

You need to notify Everence within 30 days after the cancellation event. Person(s) to be canceled from all current plans:

Name _____ Relationship _____

Name _____ Relationship _____

Address (if different than indicated in Part A above) _____
Street City State ZIP

Reason for cancellation:

Date of cancellation event* _____

Divorce/legal separation

Dependent no longer meets eligibility requirements

Other _____

Signature of employee

Date

**In most cases, cancellations are effective the last day of the month in which the individual no longer qualifies for coverage.*