Termination Due to Reduction of Hours or Unpaid Leave

1. Social Security Number	2. Group ID Number	3. Group Name	
4. Last Name	5. Suffix	6. First Name	7. M.I.

Employee No Longer Eligible   **Effective Date:** _____

☐ Employee not in a stability period and experienced a change in status (full-time to part-time)

☐ Employee no longer eligible at end of initial or standard stability period

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Eligible Employee - Voluntarily Cancels Coverage   **Effective Date:** _____

☐ Terminate coverage so that I can enroll in coverage through Health Insurance Marketplace.

A reduction in hours does not automatically make an employee ineligible for health-related coverage. The Affordable Care Act prohibits an employer from terminating health coverage when he experiences a reduction in hours within a stability period. Eligibility for life insurance and long term disability benefits, however, does end if an employee's hours are reduced below 30 hours per week.

I am voluntarily requesting that all coverage for me and my covered dependents be canceled so that I may enroll in another health plan offered through the Health Insurance Marketplace. I understand all coverage will be terminated including all life insurance and long term disability benefits.

By signing below, I certify:

- I have experienced a reduction in hours.
- The average number of hours I work each week is expected to be less than 30 hours and will remain below 30 hours for the remainder of my eligibility period.
- I understand that all insurance coverage will be canceled.
- I will enroll in another health plan offered through the Health Insurance Marketplace within 31 days of the date this health plan ends.
- I understand I will not be able to reenroll in health insurance benefits with my employer until the October open enrollment period, if I qualify, or within 31 days of a special eligibility situation.
- I, nor any of my covered dependents, will be eligible for COBRA continuation coverage as a result of this voluntary termination.

_____   _____
Subscriber's Signature   Date

_____   _____
Benefits Administrator's Signature   Date

REV. 4/15