



# Oklahoma State & Education Employees Group Insurance Board

## INSURANCE TERMINATION FORM

### EMPLOYER INFORMATION

Group ID#: \_\_\_\_\_ Division ID#: \_\_\_\_\_ Group Name: \_\_\_\_\_

### EMPLOYEE INFORMATION

SSN or Member ID # \_\_\_\_\_

Employee Name: \_\_\_\_\_  

First Name
Middle Initial
Last Name

### INSURANCE TERMINATION DATE

Please enter the last month of coverage for which premium will be paid for this employee.  
 (This may or may not be the date the employee left employment.)

Month	Year

Note: OSEEGIB does not prorate premium at termination. Premium must be paid in full month increments.

### REASON FOR TERMINATION

- Termination of Employment
- Death of Employee    Date of Death: \_\_\_\_\_
- Transferring to another employer that is insured by OSEEGIB  
     Name of the receiving employer (if known): \_\_\_\_\_
- Other (please specify): \_\_\_\_\_

**FOR OSEEGIB USE ONLY**

Reminder: It is the Insurance Coordinator's responsibility to notify the employee of COBRA, Vesting, and Retirement rights.

### CERTIFICATION SIGNATURE

I certify that this termination is in compliance with the provisions of the employer's Section 125 Plan or, if no 125 Plan is offered, is in compliance with allowed midyear coverage changes as defined by Title 26, Section 125, of the Internal Revenue Codes (as amended), and pertinent regulations.

Insurance Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Must be signed by Insurance Coordinator to be valid)