

# STATE OF NEBRASKA

## COBRA/RETIREE TERMINATION FORM

**Must be completed by the AGENCY PERSONNEL OFFICE and sent to: Personnel, Health & Life Benefits section within 14 days of termination.**

EMPLOYEE NAME (LAST, FIRST, M.I.)		SOCIAL SECURITY NUMBER	Address Book Number
ADDRESS		CITY, STATE, ZIP	
DATE OF BIRTH/AGE (65 or older also check #13)	GENDER	AGENCY NAME	
DATE OF QUALIFYING EVENT		DATE COVERAGE WILL TERMINATE	
<b>*FULL NAME (LAST, FIRST, M.I.)</b>	<b>SOCIAL SECURITY NUMBER</b>	<b>GENDER</b>	<b>DATE OF BIRTH</b>
SPOUSE'S NAME			
DEPENDENT'S NAME			
DEPENDENT'S NAME			
DEPENDENT'S NAME			

• **LIST ADDITIONAL DEPENDENTS ON BACK (if Dependent mailing address is different, please note on back of form)**

**Reason for termination of coverage (Qualifying Event); please mark one:**

1.  Voluntary termination of employment; **if YES, is the employee paying into the Retirement System: YES or NO** (circle one)
2.  Involuntary termination; **if YES, is the employee paying into the Retirement System: YES or NO** (circle one)
3.  Reduction in work hours (less than 1/2 time) OR LEAVE OF ABSENCE (circle one)
4.  Death of Employee
5.  Legal separation or divorce (legal separation as granted by a judge; or completion of six month waiting period for divorce)
6.  Dependent child ceasing to be eligible dependent (**we need dependent's SS# to process** → \_\_\_\_ - \_\_\_\_ - \_\_\_\_)  
**DATES:** married \_\_\_\_\_; less than full time student \_\_\_\_\_; quit school \_\_\_\_\_; graduated \_\_\_\_\_; full-time employment obtained (not summer job) \_\_\_\_\_; age 19 or 24 \_\_\_\_\_.
7.  Retirement (employee covered by labor contract, list contract title here \_\_\_\_\_)
8.  Retirement (employee covered by administrative procedure)
9.  Leaving State Government due to a disability
10.  Open Enrollment change from one health plan to another
11.  Open Enrollment Period for spouse
12.  Active Military Leave
13.  **Employee is 65 years of age or older**

**Choose one: Employee is**    Monthly    or    Biweekly (circle one)

INSURANCE CARRIER	TYPE OF COVERAGE	Life/LTD/LTC CODES
<input type="checkbox"/> Nebraska Blue Choice	<input type="checkbox"/> Single	
<input type="checkbox"/> BCBS Wellness PPO	<input type="checkbox"/> 2 Party, Employee & Spouse	
<input type="checkbox"/> BCBS Regular PPO	<input type="checkbox"/> 4 Party, Employee & Child(ren)	
<input type="checkbox"/> BCBS PPO	<input type="checkbox"/> Family	

**AMERITAS DENTAL (check correct plan)**

**Basic**     Single     2-Party     4-Party     Family  
**Premium**     Single     2-Party     4-Party     Family

**EYEMED VISION (check correct plan)**

**Basic**     Single     2-Party     4-Party     Family  
**Premium**     Single     2-Party     4-Party     Family

**EAP**

**YES or NO** (circle one)

**Flexible Spending AMOUNT**

List Dollar Amounts –  
 Medical → \_\_\_\_\_                      Dependent → \_\_\_\_\_

Agency:

Agency Representative:

Telephone Number:

Date: