COBRA Benefit Termination Request

1 Primary Covered Individual's Information

Primary Covered Individual's Name

Primary Covered Individual's Social Security Number

2 Termination Information

Benefit to be Terminated

Date of Benefit Termination *(Must be the last day of the month and no earlier than current month)*

☐ Terminate coverage for everyone enrolled ☐ Terminate coverage for the following:_____

Benefit to be Terminated

Date of Benefit Termination *(Must be the last day of the month and no earlier than current month)*

☐ Terminate coverage for everyone enrolled ☐ Terminate coverage for the following:_____

Benefit to be Terminated

Date of Benefit Termination *(Must be the last day of the month and no earlier than current month)*

☐ Terminate coverage for everyone enrolled ☐ Terminate coverage for the following:_____

3 Signature

Primary Covered Individual's Signature

Date

***Please mail or email form to:**

National Benefit Services, LLC
Dept 5
P.O. Box 981044
Boston, MA 02298-1044
cobra@nbsbenefits.com