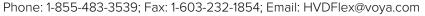
COBRA TERMINATION REQUEST

Voya Benefits Company, LLC A member of the Voya® family of companies Address: Voya Financial / Benefit Strategies, LLC PO Box 23983, New York, NY 10087-3983



Employee/QB Name (First)

SECTION 1. EMPLOYEE OR QUALIFIED BENEFICIARY (QB) INFORMATION



Health Account Solutions, including Health Savings Accounts, Flexible Spending Accounts, Commuter Benefits, Health Reimbursement Arrangements, and COBRA Administration offered by Voya Benefits Company, LLC (in New York, doing business as Voya BC, LLC). HSA custodial services provided by Voya Institutional Trust Company.

Please completely fill out this form to request for COBRA Termination. Incomplete, incorrect and/or illegible forms will be returned back to the sender and require a new form submission. Print and send completed form and send via email, fax or paper mail.

Employer Name					
Birth Date (mm/dd/yyyy) _		(OR) Social Security Number (SSN) (Required)			
Email (Required)		Daytime Phone ()_			
SECTION 2. BENEF	FIT TERMINATION IN	IFORMATION			
Check off all boxes that apply to your request. We will only process 30 day retroactive termination requests.					
Benefit	Termination Effective Date	Terminate Coverage For ALL Covered	Name of Individual(s) to Terminate		
All Benefits					
Medical					
☐ Dental					
Vision					
Other					
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Note: If termination is due to death, please provide a copy of the death certificate. If termination is due to Medicare entitlement, please provide a copy of the Medicare showing your Part B effective date IF ONLY dependent(s) are staying on COBRA.

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SECTION 3. CONTINUING DEPENDENT(S) COVERAGE ONLY if you wish to continue coverage for one or more of your dependent(s), please fill out the information below.							
Name (First)	(Last)	Relationship:	Spouse	Dependent Child			
Birth Date (mm/dd/yyyy) (Required)		Social Security Number (SSN) (Required)					
Check Off All That Apply: Medical Dental	Vision Other_						
Name (First)	(Last)	Relationship:	Spouse	Dependent Child			
Birth Date (mm/dd/yyyy) (Required)	Social Security Number (SSN) (Required)						
Check Off All That Apply: Medical Dental	Vision Other_						
Name (First)	(Last)	Relationship:	Spouse	Dependent Child			
Birth Date (mm/dd/yyyy) (Required)	Social Security Number (SSN) (Required)						
Check Off All That Apply:	Vision Other_						
SECTION 5. SIGNATURE							
I understand this submission is a request to terminate r	my COBRA coverage fo	or the specific benefit(s) indicated above. A	ny incomplete	or illegible forms			
will be returned and I am required to submit a new form	n for completion of my	request. I understand this process can tak	ke up to 14 bus	iness days and it is			
my responsibility to confirm with the insurance carrier(s	s) the termination(s) ha	ve been processed.					
Employee/QB Signature		Date					