RESET FORM

COBRA TERMINATION REQUEST

Voya Benefits Company, LLC
A member of the Voya® family of companies
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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 WEX Inc. For all other products, administration services provided in part by WEX Health, Inc.

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.

SECTION 1. EMPLOYEE OR QUALIFIED BENEFICIARY (QB) INFORMATION

Employee/QB Name *(First)* _____ *(Last)* _____

Employer Name _____

Birth Date *(mm/dd/yyyy)* _____ (OR) Social Security Number (SSN) *(Required)* _____

Email *(Required)* _____ Daytime Phone (_____)_____

SECTION 2. BENEFIT TERMINATION INFORMATION

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			
Reason			

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.

I do not want to continue coverage for any dependents on my plan(s).

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: Medical Dental Vision Other ______________________

SECTION 5. SIGNATURE

I understand this submission is a request to terminate my COBRA coverage for the specific benefit(s) indicated above. Any incomplete or illegible forms will be returned and I am required to submit a new form for completion of my request. I understand this process can take up to 14 business days and it is my responsibility to confirm with the insurance carrier(s) the termination(s) have been processed.

Employee/QB Signature ______________________ Date ______________________