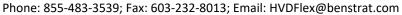
COBRA TERMINATION REQUEST

Voya Benefits Company, LLC

A member of the Voya® family of companies

Customer Service: PO Box 3938, Manchester, NH 3105-3938





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.

imployee/QB Name (First)			_ (Last)		
mployer Name					
			(OR) Social Security Number (SSN) (Required)		
mail (Required)		Daytime Phone ()_			
ECTION 2. BENEF	IT TERMINATION IN	IFORMATION			
			ive termination requests		
		IFORMATION will only process 30 day retroact	ive termination requests.		
			ive termination requests.		
	pply to your request. We	will only process 30 day retroact	ive termination requests. Name of Individual(s) to Terminate		
heck off all boxes that a	pply to your request. We	will only process 30 day retroact Terminate Coverage			
heck off all boxes that a	pply to your request. We	will only process 30 day retroact Terminate Coverage			
Benefit All Benefits	pply to your request. We	will only process 30 day retroact Terminate Coverage			
Benefit All Benefits Medical	pply to your request. We	will only process 30 day retroact Terminate Coverage			
Benefit All Benefits Medical Dental	pply to your request. We	will only process 30 day retroact Terminate Coverage			

il termination is due to medicare entitiement, please provide a copy of the medicare showing your Part B effective date in ONLY dependent(s) are staying on COBRA

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.

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 of	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 Visi	ion 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 Visi	ion 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 Visi	ion Other_							
SECTION 5. SIGNATURE								
I understand this submission is a request to terminate my CC	BRA coverage f	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 for o	completion of my	y request. I understand this process can tak	ce up to 14 bus	iness days and it is				
my responsibility to confirm with the insurance carrier(s) the	termination(s) ha	eve been processed.						
Employee/QB Signature		Date						