PUBLIC EMPLOYEES INSURANCE PROGRAM

TERMINATION FORM

QUALIFYING BENEFICIARY DATA

Employer Name: _____

Name: _____ Social Security No: _____
Last First MI

Address: _____
Street City State Zip

Phone No.: (____) _____ Date of Birth: ___/___/___ Relationship to Employee: _____

EMPLOYEE DATA

Name: _____ Social Security No: _____
Last First MI

QUALIFYING EVENT

Event Date: _____/_____/_____ Last Day of Coverage: _____/_____/

For Employee:

_____ Termination of Employment _____ Reduction in Hours _____ Non-Medical Leave of Absence

_____ Work Related Disability _____ Non-Work Related Disability _____ Early Retirement

For Dependent:

_____ Death of Covered Employee _____Divorce or Legal Separation _____ Employee's Entitlement to Medicare

_____ Child's Loss of Dependent Status

HEALTH PLAN COVERAGE

MEDICAL COVERAGE:

Medical Plan: _____ _____ Single _____ Family

Dental Plan: _____

_____ Employee + Spouse _____ Employee + Child

Send Original Form To:
Innovo Benefits Administration
PEIP Cobra
7805 Telegraph Road, Suite 110
Bloomington, MN 55438

For Innovo Benefits Administration Use Only:

Completed by:_____ Date: _____ COBRA Start: _____ End: