



CHARTER HEALTH PLAN
A big idea for small business

Employee Termination Form

Please Be Advised: All termination forms must be received within 30 days of the employee's last working day. If received after the 30 day time limit, the maximum amount refunded will not exceed the employee's one month premium (employer + employee contribution). Termination Notices must be received before the 15th of the month to be displayed on the next month's ACH notice.

Employer: _____
 Company Name Charter Health Plan Group ID #

Employee: _____
 Last Name First Name Middle Initial

 Address City State Zip

____/____/____
 Date of Birth Social Security Number Member ID #

Request for Termination of Employee Benefits Through Charter Health Plan

I certify that the above named employee is no longer employed and he/she and his/her dependents no longer meet the requirements for Group Benefits through the Charter Health Plan.

Company Representative (Please Print Name)

Signature

Title

____/____/____
Date

Employee's Last Day of Employment: ____/____/____

Please fax or mail this completed form to:

Terry O'Brien
First Benefits
306 N. Rhodes Avenue
Suite 111
Sarasota, FL 34237
FAX: (941) 363-0037