OKLAHOMA
Employees Group
Insurance Division

Employees Group Insurance Division
INSURANCE TERMINATION FORM

Employer information (to be completed by insurance coordinator)

Group ID	Division ID	Group name

Employee information

SSN or Member ID	Name (First MI Last)

Insurance termination date (last month of coverage for which premiums will be paid)

Last month and year of coverage

Note: EGID does not prorate premiums. Premiums must be paid in full-month increments.

Reason for termination

☐ Termination of employment.	Last date of employment:
☐ Death of employee.	Date of death:
☐ Transfer coverage to another EGID participating employer.	Name of receiving employer:
☐ Other (please specify):	

It is the insurance coordinator's responsibility to notify the employee of COBRA, vesting and retirement rights.

Signature (must be signed by the insurance coordinator to be valid)

I certify this termination is in compliance with the provisions of the employer's Section 125 Plan or, if no 125 Plan is offered, is in compliance with allowed midyear coverage changes as defined by 26 U.S. Code § 125 of the Internal Revenue Code (as amended) and pertinent regulations.

Insurance coordinator signature	Date