

HEALTH CARE PLANS TERMINATION OF COVERAGE FORM

(MUST BE REPORTED WITHIN 31 DAYS OF EFFECTIVE DATE)

Send Form To:

Diocese of Cleveland Health Benefits office 1404 East Ninth Street Eighth Floor Cleveland, Ohio 44114-1722 (216) 696-6525 or 621-3700 Fax (216) 621-9622

EMPLOYER	CHENT NO.	DATE	Barran de Santa anno 1994 anno 1995 anno 1995
EMPLOYEE NAME	CURRENT ADDRESS	EFFECTIVE DATE	REASON *SEE KEY
To the Company of the Section of the	and a standard COS and a high a strong and a trained of and an emitted 50 COS on 15 Special COS OF COS OF THE		
			:
			44 64 64 74 74 74 74 74 74 74 74 74 74 74 74 74
* KEY L.E. — Left Employment			
TRANS. — Transferred within the Dioc R — Retired (Does not wish to c			
D — Deceased O — Other (Please Specify)	· · · G -7		
This form is strictly for Health Care Terminations.			
GIGNED		75.47775	
SIGNED		DATE	tankan kalan kanada da sanaka san
	***************************************		·