# 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 | CLIENT NO. | DATE |
|---|---|---|
| | | |

| EMPLOYEE NAME | CURRENT ADDRESS | EFFECTIVE DATE | REASON * SEE KEY |
|---|---|---|---|
| | | | |

★ KEY

**L.E.** — Left Employment
**TRANS.** — Transferred within the Diocese (Indicate new location)
**R** — Retired (Does not wish to continue coverage)
**D** — Deceased
**O** — Other (Please Specify)

**This form is strictly for Health Care Terminations.**

SIGNED _____ DATE _____

**Pink Copy** = Health Benefits Office **White Copy** = Employer