



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 Group, Inc.
306 Rhodes Avenue, Suite 111
Sarasota, FL 34237
FAX: (941) 363-0037