



Arise Health Plan
P.O. Box 11625
Green Bay, WI 54307-1625
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BillingandEnrollment@wpsic.com

EMPLOYEE OR DEPENDENT TERMINATION FORM

PLEASE COMPLETE AND RETURN TO THE ADDRESS ABOVE.

Name of Employee: Name of Employer:

Member #: Group #: Division #:

Coverage Termination Date:

TERMINATING COVERAGE REASON

- Employment terminated. Last date of employment (submit continuation form if applicable).
Employee ineligible due to reduction of work hours. Date hours reduced
Retirement. Date of retirement
Death. Date of death
End of continuation coverage (COBRA or state continuation). Date
Dependent termination. Name: Date
Reason for termination

Employer Signature: Print Name: Date:

WAIVING COVERAGE

- Waiving coverage due to spouse or other coverage effective. Date of other coverage

If you are waiving/declining medical coverage for yourself and/or your dependents (including your spouse) because of other health coverage, you may in the future be able to enroll yourself and/or your dependents when other coverage ends, provided that you request enrollment within 30 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If you waive/decline medical coverage for yourself and/or your dependents for any other reason, you may be considered a late enrollee and subject to an 18 month pre-existing illness provision.

I proclaim that I was not pressured or forced by the employer named above, the writing agent, or Arise Health Plan into waiving the above noted coverage. I freely and voluntarily waive the above noted coverage.

This form becomes a part of your original application and is subject to the terms of the plan.

IF WAIVING COVERAGE, THE EMPLOYEE'S SIGNATURE IS REQUIRED.

Signature Print Name Date