Starmark
Small business is our only business.

NOTICE – Termination/Waiver

TO: Starmark Administration Department

FAX NO.: 847.615.3955

RE: Group Name _____ Group No. _____

Complete the information below when a member terminates employment or stops working due to a disability. The member will remain covered until the end of the month in which termination occurs or until the end of the sixth month in the case of disability. COBRA, state continuation or conversion must be offered when appropriate. Refer to the Benefit Plan or Participating Employer Administration Guide for further information.

Member's Name	Member's I.D. No.	Last Date of Employment	First Date of Disability	Expected Return Date

Complete the information below when a member remains employed, but wishes to waive the health coverage. Please be advised when applying for coverage in the future, the member may be considered a late enrollee and additional limitations and waiting periods may apply.

	Waiving Total Coverage If Applicable	Waiving Major Medical Only If Applicable	Waiving Dental Only If Applicable
Member and any dependents	☐	☐	☐
Spouse	☐	☐	☐
Child(ren)	☐	☐	☐

Member's I.D. No._____ Member's Name _____

Effective Date of Change _____

The member agrees to the above request.

_____ _____

Member Signature **Date**