

**Form must be completed entirely for all terminations including life only.**

**Please submit via secure email to Illinois School Insurance Network**

**[mwil.isinadministration@marshmma.com](mailto:mwil.isinadministration@marshmma.com)**

## Employee Information

District Name:	Lemont Township High School District 210	Social Security #:	—	—
Employee Name:		Date of Birth:	/	/
Address:		Telephone #:	—	—
City, State, Zip:		Gender:	<input type="checkbox"/> M	<input type="checkbox"/> F

Event Date:	/	/
<small>NOTE: Coverage will terminate at the end of the month in which the termination event occurs.</small>		
Reason for Termination:	<input type="checkbox"/> Left Employment <input type="checkbox"/> Death <input type="checkbox"/> Involuntary Termination <input type="checkbox"/> Retirement <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Ineligible child <input type="checkbox"/> Eligible for Other Coverage <input type="checkbox"/> Other   Describe: _____	

## List Individuals Terminating from Coverage (include employee if terming)

Name	Social Security #	Birth	Gender	Relationship
	—	/		
	—	/		
	—	/		
	—	/		
	—	/		

## Current Benefits - Terminate Coverage for:

Plan	Coverage	Plan	Notes
Medical Insurance BCBS of IL	<input type="checkbox"/> Single <input type="checkbox"/> Empl + 1 <input type="checkbox"/> Family	<input type="checkbox"/> B03881 HMO BA Plan 2 <input type="checkbox"/> 165607 PPO <input type="checkbox"/> No coverage	
Dental Insurance BCBS of IL	<input type="checkbox"/> Single <input type="checkbox"/> Empl + 1 <input type="checkbox"/> Family	<input type="checkbox"/> 270728 DPPO <input type="checkbox"/> No coverage	
Vision Insurance VSP	<input type="checkbox"/> Single <input type="checkbox"/> Empl + 1 <input type="checkbox"/> Family	<input type="checkbox"/> 12019596 Vision Plan 175 <input type="checkbox"/> No coverage	

Terminate Life Insurance:  Yes  No      Last FSA Deduction: \_\_\_\_\_  N/A

Completed by: \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_