



Termination Form

DIV 04 - Lemont Township High School District 210

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

Employee Information

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

Event Date:	<u> / /</u>
<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: <u></u>

List Individuals Terminating from Coverage (include employee if terming)

Name	Social Security #	Birth	Gender	Relationship
	<u>— —</u>	<u> / /</u>		
	<u>— —</u>	<u> / /</u>		
	<u>— —</u>	<u> / /</u>		
	<u>— —</u>	<u> / /</u>		
	<u>— —</u>	<u> / /</u>		

Current Benefits - Terminate Coverage for:

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

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

Completed by:

Date: / /

As of 01.01.2026