COBRA Continuation Termination/Change Form

**This form can be used to officially notify Igoe that you wish to terminate coverage for yourself or your enrolled dependent(s). Please note that premium refund requests may take up to 4 weeks to process as in many cases, the premium has already been sent to the insurance carrier and will need to be re-collected. If you request a premium refund, Igoe does retain the 2% administration fee.**

1. Please provide the name of your Plan Sponsor/Former Employer: Click here to enter text.
2. Please provide the name of the Qualified Beneficiary for whom coverage should be terminated and the first five digits of their Social Security Number: Click here to enter text.
3. Please provide the names of the Dependents for whom coverage should be terminated, if applicable: Click here to enter text.
4. Please provide the date you would like coverage to terminate. The date selected must be the first of the month. **If a mid-month date is selected in error, Igoe will default to the first of the month following the mid-month date indicated below**. Click here to enter date
5. Please select the plan(s) you wish to terminate:

Medical

Dental

Vision

FSA

HRA

EAP

Other Click here to enter text.

1. Please complete the following if you have signed up for the ACH program (automated recurring payments) and/or need to request a premium payment refund.

I will enter the member portal and cancel my ACH program. Please refund me any premium payments that were already processed beyond the coverage termination date. I understand that Igoe will retain the 2% administrative fee. Igoe is authorized to mail the refund to the address listed in the **Signature Section**.

Please cancel my ACH program on my behalf. I understand that manual processing of this form can take up to 10 business days and request that any premium processed during this time for coverage beyond the coverage termination date be refunded to me. I further understand that Igoe will retain the 2% administrative fee. Igoe is authorized to mail the refund to the address listed in the **Signature Section**.

I did not sign up for the ACH program but would like to request a refund of premium already submitted for coverage beyond the requested coverage termination date. I further understand that Igoe will retain the 2% administrative fee. Igoe is authorized to mail the refund to the address listed in the **Signature Section**.

Required Signature. This form must be signed by all Qualified Beneficiaries requesting the change. A Qualified Beneficiary is a person who is currently covered by the benefit that is being dropped or cancelled. This may be a spouse or dependent of the primary insurance account holder.

If the Qualified Beneficiary is below the age of 18, please check here to indicate that you have the legal authority to make benefit decisions for the minor in question:

The Qualified Beneficiary must agree to the following attestation: I, as the Qualified Beneficiary, attest that the information listed above is accurate. I further attest that I understand the information provided here will result in the cancellation of coverage and that such coverage cancellation is irrevocable and may result in the discontinuation of my COBRA eligibility period. If coverage is cancelled in order to take advantage of new enrollment opportunities due to an open enrollment period, I understand that new enrollment choices must be made prior to the enrollment deadline provided and that all necessary enrollment forms and payments must be completed.

**Signature(s) of Qualified Beneficiary and Dependent(s) over the age of 18:**

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**Address for Premium Refund:**

**Click here to enter address**