MBA/BIAW/NMTA/CAMPS/BIIT Health Insurance Trust

Change Transmittal Form

INSTRUCTIONS:

Use this form to cancel employee or dependent coverage.
The Trust Administrator must receive this form within 10 days of a participant's last day of coverage.
If your employee is opting out of coverage, please use the Waiver Form.

CANCEL EMPLOYEE COVERAGE (*Note: This also cancels dependent coverage, if applicable*.)

To cancel employees from your plan, please provide the information noted below. Coverage will cease at the end of the month in which the participant is no longer eligible or leaves the firm. Assuming timely notification, the cancellation date will be the first of the month following the employee's loss of eligibility. Contract provisions prohibit retroactive cancellation of coverage.

Name of Employee *One Employee Per Form	Social Security Number	Reason for Cancellation (Check One & Enter Date) *If Employee is Opting out of Coverage, please complete the Waiver Form
		☐ **Termination of Employment** Last Day Worked_____ ☐ **Reduction in Hours** Date Transferred to Part Time_____ ☐ **Death of Employee** Date of Death_____ ☐ **Employee Request- Cancellation of Voluntary Vision and/or Dental** Date Requested_____

Please select the type of coverage you wish to cancel ☐ All Coverages ☐ Medical ☐ Dental ☐ Vision

CANCEL DEPENDENT COVERAGE ONLY

To cancel an employee's dependent(s) from your plan, please provide the information noted below.

Name of Employee	Social Security Number	Dependent's Name	Cancellation Date

Please select the type of coverage you wish to cancel ☐ All Coverages ☐ Medical ☐ Dental ☐ Vision

CHANGE INFORMATION (Name change, correct birthdate, correct SSN, change division, etc.)

Name of Employee	Social Security Number	Description of Change

EMPLOYER AUTHORIZATION AND ACKNOWLEDGMENT

Name of Employer: _____ Employer Number: _____

The person signing this form below acknowledges and confirms that any employee and/or dependent for whom cancellation is requested had no expectation of coverage and paid no premium for coverage after the requested cancellation date.

Employer's Authorized Signature: _____ Title: _____Date:_____

Return this form to:

EPK & Associates, Inc.
15375 SE 30th Place Suite 380
Bellevue, WA 98007
Phone: (800) 545-7011 Fax: (425) 641-8114

Enrollment Changes can also be submitted online at:
www.EPKonnect.com