HealthAmerica/HealthAssurance
Eligibility Department
(717) 541-5979 - Fax

TERMINATION REPORT

Employers may complete this form to cancel their employees from HealthAmerica/HealthAssurance Coverage.

Group Number: _____
Company Name: _____
Address: _____
_____

Today's Date: _____
Invoice Period: _____
Contact Name: _____
Telephone Number: _____

Social Security #	Employee's Name Last, First, Middle Initial	Term Code*	Term Date

** Term Code ~ Reasons for Termination*

1. *Employment Terminated*
2. *Moved Out of the Area*
3. *Loss of Eligibility*
4. *Non-Payment of Premium*
5. *Other Coverage*
6. *Deceased*