TERMINATION OF COVERAGE
GROUP PLANS

RESET FORM

A. EMPLOYER INFORMATION

Employer name: _____ Employer number: _____

City: _____ State: _____ ZIP code: _____

B. EMPLOYEE INFORMATION

☐ Check if address change ☐ Check if name change

Employee name: _____ Social Security number (last four digits): _____

Mailing address: _____

City: _____ State: _____ ZIP code: _____

C. TYPES OF CHANGES (MUST BE COMPLETED FOR EMPLOYEE AND/OR DEPENDENTS)

Last date of eligibility: _____ **Last date of coverage (if different):** _____

Coverage ends at 11:59 p.m. on the date listed.

Medical, Dental, and/or Vision only may be extended to the end of the last date worked month.

Do not include continuation coverage dates — see section F for continuation.

Coverage is being terminated for (check all that apply):

☐ Self ☐ Spouse ☐ All dependent children ☐ Specific dependent children*

*Dependent: _____ Social Security number (last four digits): _____

*Dependent: _____ Social Security number (last four digits): _____

*Attach a separate sheet to list more than two dependents.

From the choices below, please indicate the reason coverage is being terminated for you and/or your dependent(s):

☐ Employment termination ☐ Working below minimum hours ☐ Death ☐ Divorce (date finalized): _____

☐ No longer want coverage ☐ Retirement (complete section E) ☐ Disability ☐ Other: _____

D. PRODUCT TERMINATION (INDICATE COVERAGE BEING TERMINATED BY CHECKING THE APPROPRIATE BOX(ES).)

Please check which coverage is to be terminated:

☐ All ☐ Medical ☐ Dental ☐ Vision ☐ Term Life ☐ Optional Life ☐ Child Life

☐ AD&D ☐ ESADD ☐ SSADD ☐ Disability ☐ Spouse Life ☐ Retiree Life ☐ Spouse Optional Life

GuideStone® does not honor severance packages. If medical, dental, and/or vision continuation is desired and offered by the employer, please complete section F on next page or submit a *Request for Medical, Dental, and/or Vision Continuation Group Plans* form (8020) within 60 days of the last date of eligibility.

Note: An employer may not offer continuation coverage in the event that the employer terminates the employee upon a finding of gross misconduct.

Employer's Authorized Representative signature: _____ **Date:** _____

Printed name and title of Employer's Authorized Representative: _____

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GuideStone®

E. RETIREMENT PRODUCTS ONLY (INDICATE CHOICES BY CHECKING THE APPROPRIATE BOX(ES).)

☐ 65 or older choosing GuideStone Medicare plans. If Medicare-eligible, complete *Medicare-coordinating Plans – Retiree Enrollment (Group Plans)*.

☐ 65 or older leaving GuideStone insurance

☐ Under 65 continuing core plan: ☐ For self ☐ For spouse ☐ For eligible children

RETIREE LIFE, DENTAL & VISION

Note: Term life can only be continued if held prior to retirement, and the amount in force will be reduced to $20,000 or the retiree can choose a lower benefit amount. "Spouse coverage is available up to ½ of the retiree's coverage, not to exceed 50%.

☐ I would like to keep my dental coverage.

☐ I would like to keep my vision coverage.

☐ I would like to keep the following term life amount: ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000

☐ I would like to keep the following term life amount for my spouse: ☐ $5,000 ☐ $7,500 ☐ $10,000

F. REQUEST FOR MEDICAL, DENTAL, AND/OR VISION CONTINUATION

Request medical continuation for*: ☐ Employee only ☐ Employee and dependent(s) ☐ Dependent(s) only

Request dental continuation for*: ☐ Employee only ☐ Employee and dependent(s) ☐ Dependent(s) only

Request vision continuation for*: ☐ Employee only ☐ Employee and dependent(s) ☐ Dependent(s) only

***This provision is only available if your employer elects it.**

If continuation is for a dependent only, complete the following:

Dependent name: _____ Birthdate: _____

Dependent Social Security number (last four digits): _____ Telephone: _____

Street address: _____

City: _____ State: _____ ZIP code: _____

Last day of full-time eligibility for coverage: _____

Eligibility for medical, dental, and/or vision coverage ceased because: _____

Last date of continuation coverage if less than maximum eligible period described below (coverage ends at 11:59 p.m. on the date listed):

_____

I understand that this request must be made within 60 days of the date my Group Plans medical, dental, and/or vision plan terminates. I further understand that this request, if approved, will permit me (and my eligible dependents, if applicable) to continue participation in the Group Plans medical, dental, and/or vision plan for not more than 18 or 36 months (depending on the reason(s)* for termination of coverage) after the date I became ineligible for medical, dental, and/or vision plan. I understand that I become ineligible for medical continuation coverage when I become Medicare-eligible. I understand that dependent-only continuation coverage will be charged at the Employee or Employee + Child rate.

*18 Months

- Termination of employment
- Loss of coverage due to reduction in the number of hours worked
- Elimination of eligible class of employees

*36 Months

- Divorce or legal separation from employee
- Loss of dependent child status (e.g., children who reach the maximum age limit under the plan)

I agree to promptly notify the above-named employer if I become covered as an employee or dependent under another group medical, dental and/or vision plan. I further understand all other coverage will cease (or ceased) on the date I became ineligible for such coverages.

Applicant's signature: _____ Date: _____

Employer's Authorized Representative signature: _____ Date: _____

Email to: *Group.Insurance@GuideStone.org**

***This is an unmonitored inbox for form submission ONLY.**