NHAD Services, Inc - Insurance Division
PO Box 2337
Concord, NH 03302-2337
800-852-3372 or (603) 224-2369
Fax (603) 226-0898

NOTICE OF TERMINATION OF COVERAGE

Please complete this Notice within 48 hours of termination and submit to NHADA immediately.
Do not use this form for an employee's voluntary cancellation of coverage.

Name _____

Address _____

Social Security # _____

Employer Name _____

_____ _____

Signature of Employer's Representative Title

REASON FOR TERMINATION OF COVERAGE:

○ Employee Voluntarily Terminated Employment	Last Day of Employment _____
○ Employee Involuntarily Terminated by Employer	Last Day of Employment _____
○ Employee Terminated Due To Lay-Off	Last Day of Employment _____
○ Employee Ineligible Due To Reduced Hours	Date of Event _____
○ Employee Deceased	Date of Event _____

REMINDER

NHADA will not guarantee receipt of faxed documents. Please follow-up with a phone call or mail original document(s) to NHADA. Please retain a copy for your records.

---------- NHADA Use Only ----------

Loc.# _____ **Coverage End Date** _____ **DOB** ____/____/____

Medical	_____	**Coverage**	_____	**Group #**	_____
Dental	_____	**Coverage**	_____	**Group #**	_____
Vision	_____	**Coverage**	_____		
Life	_____	**Volume**	_____	**Dep Life**	_____

☐ **Involuntary** ☐ **Voluntary**