Orion Health
Insurance Pool

TERMINATION OF EMPLOYMENT/BENEFITS FORM

Forms must be submitted to the pool administrator within 30 days of the qualified life event or termination, except as noted in the Plan Document/Summary Plan Description. Failure to submit forms within the required period will impact the participant's benefits and/or enrollment. Orion is not responsible for untimely form submission, or for lost forms.

Employer: _____

TERMINATION REASON (EMPLOYEE ONLY)

Termination of employment (date) _____ **, 20** _____

Please check reason for termination:

- ☐ Termination/Layoff/Retirement
- ☐ Reduction in Hours so Ineligible for Benefits
- ☐ Medicare or Medicaid Entitlement
- ☐ Voluntary Termination of Benefits
- ☐ Gross Misconduct
- ☐ Death of Employee without Dependents
- ☐ Death of Employee with Dependents
- ☐ Administrative Error
- ☐ New Retiree
- ☐ USERRA Military Leave

☐ Other (explain)

MEMBERSHIP INFORMATION

Employee Last Name	First Name	Middle Initial

Mailing Address	Social Security #

City	State	Zip

Gender	Date of Birth (Month/Day/Year)	Daytime Phone Number	Marital Status
☐ Male ☐ Female			☐ S ☐ D ☐ W ☐ M

ENROLLMENT INFORMATION

☐ Core Plan ☐ HDHP ($1,500) ☐ HDHP ($3,000) LTD $_____

- ☐ Member only
- ☐ Member & Spouse/Domestic Partner
- ☐ Member & Children
- ☐ Member & Family
- ☐ Vision Member only
- ☐ Vision for Spouse/Domestic Partner
- ☐ Vision for Self & Children
- ☐ Vision for Self & Family
- ☐ Dental Member only
- ☐ Dental for Spouse/Domestic Partner
- ☐ Dental for Self & Children
- ☐ Dental for Self & Family

☐ VSP ☐ AVESIS
☐ Vision Employee only
☐ Vision for Self + 1 Dependent
☐ Vision for Self + 2 Dependents

Additional Life Amounts	Premiums per Month
Employee _____	$ _____
Spouse _____	$ _____
Child _____	$ _____

FOR HR USE ONLY – DO NOT WRITE BELOW THIS LINE

Date of Hire: _____ **Coverage Effective Date:** _____

Employer Signature: _____ **Date:** _____

TIFF-ORION-TERM REV. 1/16

PINK – ORION **WHITE – EMPLOYER** **CANARY – EMPLOYEE**