MILWAUKEE PUBLIC SCHOOLS

BENEFITS TERMINATION FORM

Employee I.D.: ______________

EMPLOYEE INFORMATION

CHOOSE ONE:
- ☐ Terminate Employee Plan (will also terminate any dependents on plan)
- ☐ Terminate Dependent(s) Only (please fill out dependent information below)

EMPLOYEE NAME Last, First, Middle Initial	Medical	Dental	Date of Birth	Sex	Social Security Number	Disabled	Other Coverage
	☐ Term	☐ Term	____/____/____	☐ F ☐ M	_____-____-______	☐ Yes ☐ Medicare Eligible	☐ Yes ☐ No

DATE OF EVENT: ____________________

REASON FOR CHANGE

- ☐ Marriage
- ☐ Divorce, Legal Separation or Annulment
- ☐ Birth/Adoption
- ☐ Death
- ☐ Dependent - No Longer Eligible (explain below)
- ☐ Significant cost change
- ☐ Significant reduction of coverage
- ☐ Change in employment status
- ☐ Change in coverage under another employer's plan
- ☐ COBRA Qualifying Event
- ☐ FMLA Leave
- ☐ Judgment, decree or court order
- ☐ Medicare or Medicaid entitlement

Explain (required):____

____

SPOUSE/DEPENDENT INFORMATION

Spouse or Dependent Name	Medical	Dental	Date of Birth	Relation	Sex	Social Security Number	Disabled	Other Coverage
	☐ Term	☐ Term	____/____/____		☐ F ☐ M	_____-____-______	☐ Yes ☐ Medicare Eligible	☐ Yes ☐ No
	☐ Term	☐ Term	____/____/____		☐ F ☐ M	_____-____-______	☐ Yes ☐ Medicare Eligible	☐ Yes ☐ No
	☐ Term	☐ Term	____/____/____		☐ F ☐ M	_____-____-______	☐ Yes ☐ Medicare Eligible	☐ Yes ☐ No
	☐ Term	☐ Term	____/____/____		☐ F ☐ M	_____-____-______	☐ Yes ☐ Medicare Eligible	☐ Yes ☐ No

OTHER INSURANCE (Including Medicare)

Subscriber	Employer	Health	Rx Coverage	Insurance Company	Policy/ I.D. No.	Effective Date	Medicare Part A/B
		☐ Yes ☐ No	☐ Yes ☐ No				

I certify that the above information is complete, true, and correct subject to State, Federal, and Board policy, insurance fraud penalties governing eligibility for and payment of health and dental insurance benefits for myself and my claimed dependents. I have shared the "Notice of Right to Continue Group Health and/or Dental Insurance Coverage" with all eligible family members. I have read and understand the Terms and Conditions on the reverse side of this Benefits Termination Form, and I have completed the required forms and/or provided documentation. As information requested on these forms changes, I understand I must promptly inform MPS Department of Benefits and Compensation in writing of the changes within 31 calendar days of a qualifying family status change or 60 calendar days for birth/adoption, loss of Medicaid or SCHIP. Failure to provide such written notice may result in (a) you being liable to MPS for overpaid benefits and any loss by MPS and its insurer in addition to aforementioned disciplinary action and (b) loss of coverage or denial of benefits for your dependents. MPS reserves the right to determine eligibility and obtain all necessary information to accomplish same. (See Terms and Conditions on reverse side). I certify the information to be true and correct to the best of my knowledge. I understand that the Section 125 plan administrator will review my request for a change in election in accordance with the laws governing Section 125 plans and the plan documents.

Signature: ________________________ Phone No.: ________________ Date: __________

Address: ________________________ City: ______________State: _____ Zip Code: __________

INSTRUCTIONS TO COMPLETE THE BENEFITS TERMINATION FORM

Please complete the Milwaukee Public Schools Benefits Termination Form if: terminating your or your dependent's coverage as the result of a family status change or other qualifying event.

Any missing information will result in this application being returned.

1) Fill out your **EMPLOYEE INFORMATION** completely.
2) Check ONE box indicating if you are terminating your plan, or the plan for your dependents.
3) Indicate the **DATE OF EVENT** that is causing you to terminate benefits. If approved, coverage will be terminated at the end of the month in which we receive this form.
4) Select a **REASON FOR CHANGE**, and explain this reason in the given space.
5) Complete the **SPOUSE/DEPENDENT INFORMATION** only if you are terminating dependents from your plan.
6) If you are terminating coverage because of other coverage, please provide this information in **OTHER INSURANCE**.
7) **Please retain a copy of the Benefits Termination Form for your records. We encourage you to return this original form to the Department of Benefits and Compensation in person and bring a copy with you so that we can date and time stamp the copy as received for your records.** If you do not deliver this form in person, please return it to **Milwaukee Public Schools, Office of Human Capital, Department of Benefits and Compensation, 5225 West Vliet Street, Room 124, Milwaukee, WI 53208.**

TERMS AND CONDITIONS

1) I hereby request the termination for the person(s) listed and agree that my dependents and I shall abide by the provisions of coverage in the service agreement.
2) I understand enrollment is subject to all of the terms and conditions on the Master Group Policyholder Agreement with the provider I have chosen.
3) I hereby authorize deductions from my earnings of the required contributions, if any, toward the cost of the monthly premium required by a collective bargaining agreement or terms and conditions of employment.
4) I consent and authorize any physician, dentist, consultant, hospital, or other person by whom any diagnosis, medical, surgical or dental treatment, or advice has been rendered to release pertinent medical, surgical, dental reports and records as requested to the insurance plan I selected subject to all applicable provisions of the Health Insurance Portability and Accountability Act of 1996.
5) I understand that the termination of coverage is subject to review by the Section 125 plan administrator in accordance with the laws governing Section 125 plans and the plan documents.
6) Changes permitted are limited to those consistent with the reason for the change.
7) I certify that the above information is complete, true, and correct subject to State, Federal and Board policy insurance fraud penalties governing eligibility for and payment of health and dental insurance benefits for myself and my claimed dependents. MPS reserves the right to pursue appropriate disciplinary action against you, up to and including termination of your employment with MPS, as well as any available legal remedies to recover benefits wrongfully paid on behalf of ineligible dependent(s) including notification to local law enforcement authorities regarding possible insurance fraud. As information requested on this form changes, I understand I must promptly inform MPS Department of Benefits and Compensation in writing of the changes – within 31 calendar days of a Qualifying Family Status Change, and within 60 calendar days for birth/adoption, loss of Medicaid or SCHIP. Failure to provide such written notice may result in (a) you being liable to MPS for overpaid benefits and any loss by MPS and its insurer in addition to aforementioned disciplinary action and (b) loss of coverage or denial of benefits for your dependents.
8) MPS reserves the right to determine eligibility and obtain all necessary information to accomplish this. MPS also retains the right to conduct periodic audits, including random audits for eligibility verification. I have shared the "Notice of Right to Continue Group Health and/or Dental Insurance Coverage" with all eligible family members.