

MEDICARE-COORDINATING PLANS TERMINATION FORM GROUP PLANS

Important: This form must be received by GuideStone® no later than the 25th of the month of the desired termination date. Medicare-coordinating plans can only be terminated the last day of the month.

EMPLOYEE/RETIREE INFORMATION

Employee first name: _____ MI: _____ Last name: _____

Mailing address: _____

City: _____ State: _____ ZIP code: _____

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

EMPLOYER INFORMATION

Employer name: _____

Employer address: _____

City: _____ State: _____ ZIP code: _____

Employer number: _____ Email: _____

Please terminate the following coverage on: _____

Check one

Coverage option — Please check

Senior Plan For myself For spouse For dependent: _____

Senior Plus Plan For myself For spouse For dependent: _____

Care Basic Plan For myself For spouse For dependent: _____

Care Plus Plan For myself For spouse For dependent: _____

Care Today Plan For myself For spouse For dependent: _____

Senior Plan – No Rx For myself For spouse For dependent: _____

Senior Plus Plan – No Rx For myself For spouse For dependent: _____

TERMINATION REASON

Death Date of death: _____

Withdrawal Other carrier No longer eligible

AUTHORIZED SIGNATURES

Employee Signature: _____ Date: _____

Employer's authorized representative signature: _____ Date: _____

Completed form may be emailed to: Group.Insurance@GuideStone.org

