CANCELLATION FORM

This form must be completed by the employer or authorized representative and received within 30 days of the event.

ssa
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an Excellus company

Company Information

SSA Member ID# ☐☐☐☐☐

Company Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Type of Cancel

○ **Company**
○ **Individual Employee (Use separate form for each individual being cancelled)**

Individual Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Dependents of employee will automatically be cancelled along with the employee (use enrollment/change form to remove dependent only)

Coverages to be Cancelled

○ **All** ○ **Health** ○ **Dental** ○ **Disability** ○ **Vision**
○ **Life - All** ○ **Life - Spouse** ○ **Life - Dependent** ○ **AD&D**

Reason for Cancellation Select one and complete event date(s)

○ **Left Employment Date** Note: The "Left Employment Cancel Date" is the 1st of the month following the "Left Employment Date" or later, never earlier

☐☐ / ☐☐ / ☐☐☐☐ ☐☐ / ☐☐ / ☐☐☐☐

Left Employment Date **Left Employment Cancel Date**

○ **Left Employment Due to Disability** ☐☐ / ☐☐ / ☐☐☐☐ Cancel date will be 1st of month following date entered.

○ **COBRA Expiration Date** ☐☐ / ☐☐ / ☐☐☐☐

○ **COBRA Non-Pay** ☐☐ / ☐☐ / ☐☐☐☐

○ **Date of Death** ☐☐ / ☐☐ / ☐☐☐☐

○ **Employee Request Date** ☐☐ / ☐☐ / ☐☐☐☐ Cancel date will be 1st of month following date entered or date received by SSA, whichever is later.

○ **Cost Request Date** ☐☐ / ☐☐ / ☐☐☐☐ Cancel date will be 1st of month following date entered or date received by SSA, whichever is later.

○ **Reduction in Hours** ☐☐ / ☐☐ / ☐☐☐☐ Cancel date will be 1st of month following date entered.

○ **Insurance Elsewhere Date** ☐☐ / ☐☐ / ☐☐☐☐ Cancel date will be 1st of month following date entered.

New Carrier:____

○ **Company Dissolved Date** ☐☐ / ☐☐ / ☐☐☐☐ Cancel date will be 1st of month following date entered (company cancel only).

○ **No Active Employees Date** ☐☐ / ☐☐ / ☐☐☐☐ Cancel date will be 1st of month following date entered (company cancel only).

**All back dated cancels will be subject to claims review.*

Employer Authorization

X ____ **Date** ☐☐ / ☐☐ / ☐☐☐☐

Authorized Signature

Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

(over)

C O B R A

COBRA/NYS
CONTINUATION OF BENEFITS ELECTION FORM

This form must be completed if you, the employer, administer your own COBRA benefits.

COBRA/NYS Continuation of Benefits

This is to indicate whether the employee has opted for a "COBRA/NYS Continuation of Benefits" extension. If the information is filled out below, the employee will be continued as part of your group and billing.

Company Information

SSA Member ID# ☐☐☐☐☐

Company Name ______________________________

Employee to be Reinstated on Company Billing

Individual Name ______________________________

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Reason for Cancellation

Reason for cancellation ______________________________

Qualifying Event Date ☐☐ / ☐☐ / ☐☐☐☐ **Cancellation Date** ☐☐ / ☐☐ / ☐☐☐☐

Employer Authorization

X ______________________________ **Date** ☐☐ / ☐☐ / ☐☐

Authorized Signature

Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

Send completed to: SSA, P.O. Box 130, 107 Prospect Street, Schoharie, NY 12157-0130

If you would like SSA to administer COBRA/NYS Continuation of Benefits on your behalf--which includes completion of paperwork, record and direct billing to the employees--please call the Member HelpLine at (800) 909-2772 for information about this service.