# COBRA DROP COVERAGE OR EARLY TERMINATION FORM

Samaritan Health Plans

This form is to be filled out when dropping part of your existing COBRA Continuation Coverage or terminating COBRA Continuation Coverage early.

Please follow the procedures listed below:

1) Complete, sign, and date this form and make a copy for your records.
2) Mail this form back to: Samaritan Health Plans, PO Box M, Corvallis, OR 97339
3) The form may be hand delivered to: Samaritan Health Plans, 2300 NW Walnut Blvd, Corvallis, OR 97330

| SUBSCRIBER INFORMATION | | | | |
|---|---|---|---|---|
| LAST NAME FIRST MI | | SOCIAL SECURITY NUMBER | | SUBSCRIBER ID |
| STREET ADDRESS | APT# | CITY | STATE | ZIP |
| DAYTIME PHONE # | ALTERNATE PHONE # | | DATE OF BIRTH | GENDER |

## DROPPING PART OF COBRA CONTINUATION COVERAGE

Please follow the procedures listed below:

1) List ALL members that need some or all coverage dropped.
2) ONLY mark the coverage you want dropped for each member.
3) Sign and date the bottom of the form.

I am requesting to drop the following COBRA Continuation Coverage as indicated below:

Effective date of dropped coverage _____/_____/_____
Month Day Year

| LAST FIRST MI | DATE OF BIRTH | SSN | RELATIONSHIP TO SUBSCRIBER/GENDER | COVERAGE OPTION TO DROP |
|---|---|---|---|---|
| SUBSCRIBER | Same as above | Same as above | Self / Same as above | Medical/Pharmacy ☐<br>Vision/Dental ☐<br>FSA contribution ☐ |
| | | | | Medical/Pharmacy ☐<br>Vision/Dental ☐ |
| | | | | Medical/Pharmacy ☐<br>Vision/Dental ☐ |
| | | | | Medical/Pharmacy ☐<br>Vision/Dental ☐ |
| | | | | Medical/Pharmacy ☐<br>Vision/Dental ☐ |

## EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

Please fill out this section to early terminate all coverage for all covered members and verify with your signature below.

*I choose to forfeit COBRA Continuation Coverage rights for myself and my dependents by terminating early.*

Effective date of early termination _____/_____/_____
Month Day Year

Only use this Early Termination section if you want to terminate ALL coverage for ALL members.
If dropping only a portion of the coverage or covered members, please fill out page 1 of this form.

Signature Today's Date

Print Name Relationship to individual(s) listed above

Address Telephone Number

City, State, Zip Alternate Telephone Number

### FOR OFFICE USE ONLY:

Coverage after drop:

| Samaritan Choice Plans/Pharmacy: | Vision/Dental: | FSA: |
|---|---|---|
| ☐ Wellness ☐ Wellness Incentive ☐ High Deductible | ☐ Willamette ☐ Delta | ☐ |

Premiums to be billed after drop:

| Medical/Pharmacy: | Vision/Dental: | FSA: |
|---|---|---|
| ☐ Sub Only ☐ Sub/Spouse ☐ Sub/Dep ☐ Family<br>☐ Dep Only ☐ Spouse Only ☐ Spouse/Dep | ☐ Sub Only ☐ Sub/Spouse ☐ Sub/Dep ☐ Family<br>☐ Dep Only ☐ Spouse Only ☐ Spouse/Dep | ☐ |

Termination date for the dropped coverage: ____/____/____ New Sub ID needed: ☐ Yes

Early termination of all members: ☐ Yes COBRA Early Termination Date: ____/____/____

NOTES: