HEALTH PLAN TERMINATION FORM

Please Print

HBAT
Home Builders Association OF TENNESSEE BENEFITS TRUST

Section 1: Employer Information

Employer Name (Group Name):

_____

Federal Tax Identification #: _____

To be Completed by Plan

Group #

Address: _____
Street Address Suite City State Zip

Phone: ( )_____ Fax: ( )_____ E-Mail Address: _____

Section 2: Reason for Termination

I/We am terminating the group from The Plan because (check box that applies):

- ☐ I am offering coverage to my eligible employees through another health carrier.
- ☐ I am no longer offering medical benefits to any employees.
- ☐ I no longer have any employees eligible for benefits.
- ☐ Other, please explain. _____

Section 3: Termination Agreement

I/We hereby request that coverage from HBAT Benefits Trust (HBATBT) for all employees enrolled as part of the Employer/Group identified in Section One of this form be terminated as of the last day of the month of _____, 20_____. I/We understand that HBATBT is only responsible for the expenses incurred while this coverage was in force. I/We understand that no benefits are payable for expenses incurred after the Group Termination Date shown in Section Four of this form, even if said expenses were incurred as the result of an accident, injury or disease that occurred, began or existed while coverage was in force. I/We understand that all Employers/Groups who elect to terminate coverage from HBATBT are required to provide HBATBT with written notice no less than 30 days prior to the end of the then current calendar month (Minimum Termination Notice). If I/We should fail to provide the Minimum Termination Notice, it is understood that I/We will be responsible for paying all Health Care Fees that would otherwise be due until the end of the subsequent calendar month.

Notwithstanding any qualifying life event as defined in 26 CFR 1.125-4, I/We understand that a participating Employer/Group that terminates coverage with HBATBT shall be liable for: (1) the administration of any and all claims associated with or caused by its Employees and or their Dependents, whether reported or processed and (2) services from which funds, claims payments, and or premiums have not been provided.

I/We understand that the responsibility to offer continuation and or COBRA coverage for Employees lies with the Employer/Group. If new coverage from another carrier is not being purchased, then, I/We must take responsibility for offering continuation and or COBRA to all covered Employees.

Name: (Please print):_____

Signed:_____ **Date:**_____

Section 4: MGA/TPA/Plan Use Only (Section Must Be Completed to Validate Termination)

Group Termination Date: ____/____/____ **Date Filed:** ____/____/____

Name (Please Print): _____ **Signature:** _____