HEALTH AMERICA
HEALTHASSURANCE
Coventry Health Care Plans

HealthAssurance
Attn: Eligibility Department
PO Box 67103
Harrisburg, PA 17106-7103
717-541-5979 Fax

TERMINATION REPORT

Employers must complete this form to terminate their employees from HealthAssurance coverage.

Today's Date:	**Contact Name:**
Name of Company:	**Contact Title:**
Street Address:	**Contact's Signature:**
City, State & Zip Code:	**Phone Number:**
Group Number:	**Fax Number:**
Invoice Period:	**Email Address:**

Subscriber Number	Social Security # Employee Number	Employee's Name Last, First, Middle Initial	Reason Code	Term Effective Date

* Reasons For Termination *

1. Terminated Employment
2. Moved out of Area
3. Loss of Eligibility
5. Changed to Another Carrier
9. Deceased