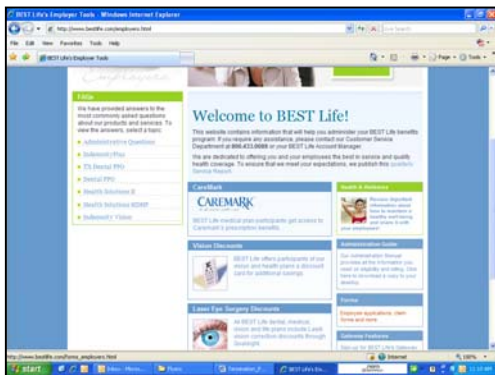


## How to Terminate an Employee's or Dependent's Coverage

With BEST Life, terminating the coverage of an employee or dependent is easy to do in just a few simple steps!



1. As soon as you are aware of the need to terminate the coverage for an employee or dependent, you can submit the terminations directly online by going to [www.bestlife.com](http://www.bestlife.com). Just click on the "Sign-in" button at the top of our website, select "Employers" and login.
2. Or, click on the "Employers" button at the top of our website and then on "Forms" to download the Termination Form. You can either fax that in to (208) 893.5040 or email a completed electronic copy to [cs@bestlife.com](mailto:cs@bestlife.com).

We've also provided a copy of the Termination Form on the back of this flyer for your convenience.

If you are terminating coverage for employees or dependents that no longer want coverage but who are still eligible, please use the "Other" section on the Termination Form. (See reverse.)

To ensure that your account is credited by the next billing statement, please notify BEST Life of any terminations immediately. Termination requests received after one month's time will not be credited to your account.

If you still have questions, please do not hesitate to contact our **Customer Service Department** at (800) 433-0088 (Monday through Thursday, 7am to 5pm PST, Fridays 7am to 3pm PST) or at [cs@bestlife.com](mailto:cs@bestlife.com).

## Termination Form

**Please complete this form to terminate coverage for an employee and/or the employee's dependents.**

Company Name		Customer #	
Employee Name – Last	First	Middle Initial	Social Security Number - -

**Terminate coverage for:**

<b>Check one:</b> <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Only <input type="checkbox"/> Spouse Only	<input type="checkbox"/> Children Only <input type="checkbox"/> One Child Only, Provide Name: _____	<b>Terminate coverage for (check all that apply):</b> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life	<b>COBRA:</b> <input type="checkbox"/> Offer COBRA <input type="checkbox"/> Term COBRA	<b>Requested Term Date</b> / /
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**REASON FOR TERMINATION OF COVERAGE (check one):**

<input type="checkbox"/> Employee terminated employment. Last day of full-time employment: ____ / ____ / ____	<input type="checkbox"/> Employee no longer eligible. Please explain:
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<b>Employer Signature (in black ink)</b>	<b>Print Name</b>	<b>EMAIL ADDRESS*</b>	<b>Date</b>
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<input type="checkbox"/> Other coverage	<input type="checkbox"/> Death	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Other: _____
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<b>Employee Signature (in black ink)</b>	<b>Print Name</b>	<b>EMAIL ADDRESS*</b>	<b>Date</b>
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Photocopy if more forms are required

\* Email addresses are for sending confirmations only and will not be used for any other purposes.

**To submit this request for termination of coverage:**

**Mail to:**  
 BEST Life and Health Insurance Company  
 Attn. Administration  
 2505 McCabe Way  
 Irvine, CA 92614

**Email to:** [cs@bestlife.com](mailto:cs@bestlife.com)

**Fax to:** Attn. Administration, 208.893.5040

**PLEASE NOTE:** Do not make adjustments on your bill for terminated employees or dependents. When termination of coverage is processed, the adjustment will appear on your next bill.