



# Termination Form

DIV 22– Southern Will County Cooperative for Special Education (SOWIC)

**Form must be completed entirely for all terminations including life only.**  
**Please submit via secure email to Illinois School Insurance Network**  
**[mwil.isinadministration@marshmma.com](mailto:mwil.isinadministration@marshmma.com)**

## Employee Information

|                             |   |
|-----------------------------|---|
| District Name: <u>SOWIC</u> | Social Security #: <u>    —    —</u>                          |
| Employee Name: _____        | Date of Birth: <u>    /    /</u>                              |
| Address: _____              | Telephone #: <u>    —    —</u>                                |
| City, State, Zip: _____     | Gender: <input type="checkbox"/> M <input type="checkbox"/> F |

|                         |   |
|-------------------------|---|
| Event Date: _____       | <i>NOTE: Coverage will terminate at the end of the month in which the termination event occurs.</i>   |
| Reason for Termination: | <input type="checkbox"/> Left Employment <input type="checkbox"/> Death<br><input type="checkbox"/> Involuntary Termination <input type="checkbox"/> Retirement<br><input type="checkbox"/> Leave of Absence <input type="checkbox"/> Ineligible child<br><input type="checkbox"/> Eligible for Other Coverage <input type="checkbox"/> Other   Describe: _____ |

## List Individuals Terminating from Coverage (include employee if terming)

| Name | Social Security # | Birth | Gender | Relationship |
|------|-------------------|-------|--------|--------------|
|      | — —               | / /   |        |              |
|      | — —               | / /   |        |              |
|      | — —               | / /   |        |              |
|      | — —               | / /   |        |              |
|      | — —               | / /   |        |              |

## Current Benefits - Terminate Coverage for:

| Plan                                   | Coverage                          | Plan  | Notes |
|--|-----------------------------------|---|-------|
| <b>Medical Insurance</b><br>BCBS of IL | <input type="checkbox"/> Single   | <input type="checkbox"/> B14366 HMO BA Plan 3     |       |
|  | <input type="checkbox"/> Empl + 1 | <input type="checkbox"/> B01776 HMO BA Plan 4     |       |
|  | <input type="checkbox"/> Family   | <input type="checkbox"/> 165622 PPO               |       |
|  |                                   | <input type="checkbox"/> 165602 HDHP w/ HSA       |       |
|  |                                   | <input type="checkbox"/> No coverage              |       |
| <b>Dental Insurance</b><br>BCBS of IL  | <input type="checkbox"/> Single   | <input type="checkbox"/> 270728 DPPO 1000         |       |
|  | <input type="checkbox"/> Empl +1  | <input type="checkbox"/> No coverage              |       |
|  | <input type="checkbox"/> Family   |   |       |
| <b>Vision Insurance</b><br>VSP         | <input type="checkbox"/> Single   | <input type="checkbox"/> 12019596 Vision Plan 175 |       |
|  | <input type="checkbox"/> Empl +1  | <input type="checkbox"/> No coverage              |       |
|  | <input type="checkbox"/> Family   |   |       |

Terminate Life Insurance:  Yes  No      Last FSA Deduction: \_\_\_\_\_  N/A

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_