ILLINOIS SCHOOL Insurance Network

Termination Form

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

Employee Information

District Name: Wilco Area Career Center

Employee Name: _____

Address: _____

City, State, Zip: _____

Social Security #: ___ — ___ — _____

Date of Birth: ___ / ___ / _____

Telephone #: ___ — ___ — _____

Gender: ☐ M ☐ F

Event Date:	/ / _____
	NOTE: Coverage will terminate at the end of the month in which the termination event occurs.
Reason for Termination:	☐ Left Employment ☐ Death ☐ Involuntary Termination ☐ Retirement ☐ Leave of Absence ☐ Ineligible child ☐ Eligible for Other Coverage ☐ Other | Describe:_____

List Individuals Terming from Coverage (include employee if terming)

Name	Social Security #	Birth Date	Gender	Relationship
	— —	/ /		
	— —	/ /		
	— —	/ /		
	— —	/ /		
	— —	/ /		
	— —	/ /		

Current Benefits - Terminate Coverage for:

Plan	Coverage	Plan	Notes
Medical Insurance BCBS of IL	☐ Single ☐ Empl + 1 ☐ Family	☐ B03881 HMO BA Plan 2	
		☐ B14332 HMO BA Plan 3	
		☐ B01776 HMO BA Plan 4	
		☐ 165616 PPO	
		☐ 165602 HDHP	
		☐ No coverage	
Dental Insurance BCBS of IL	☐ Single ☐ Empl +1 ☐ Family	☐ 270728 DPPO 1000	
		☐ No coverage	
Vision Insurance VSP	☐ Single ☐ Empl +1 ☐ Family	☐ 12019596 Vision Plan 175	
		☐ No coverage	

Terminate Life Insurance: ☐ Yes ☐ No

Completed by: _____ Date: ___ / ___ / _____