win
wellness insurance network

WIN Termination CHECKLIST

Please complete this form for all terminations and submit it to WIN Administration

Library Name: _____

Section Number: _____

Employee Name: _____

Termination Reason: _____

Termination Date: _____
(Must be submitted within 30 days of effective date)

Terminate coverage for:

_____ Employee

_____ Spouse Name of spouse:_____

_____ Children Name of children:_____

_____

_____ Domestic Partner Name of Partner:_____

- **Must complete the Statement of Termination of Domestic Partnership form if the relationship has ended. The form needs to be notarized and the copy sent to WIN Administration.**

Terminate the following coverage:

_____ Health Insurance (BCBS) (also automatically termed from BCBS vision)

_____ Dental Insurance (BCBS)

_____ Life and Disability Insurance (Dearborn National)

_____Basic Life and AD&D

_____Short Term Disability

_____Long Term Disability

Please send a copy of this completed form to:

WIN Administration
Email: MWIL.WinAdministration@MarshMMA.com

Remember to keep a copy of all forms for the library's personnel files