



NORTH CAROLINA
ASSOCIATION OF COUNTY COMMISSIONERS

SUBSCRIBER TERMINATION FORM

The County Health Plan

Group Name _____

Subscriber SSN Number _____

Subscriber Name _____
Last First M.I.

Last Address of Record _____

Date Employment Ends _____
Month Day Year

Date Coverage Terminates _____
Month Day Year
(date through which coverage extends until midnight)

COBRA Qualifying Event YES _____ NO _____

If Yes, Check all that Apply:

_____ Termination of Employment (Voluntary) _____ Reduction in Hours (Voluntary)

_____ Termination of Employment (Involuntary) _____ Reduction in Hours (Involuntary)

_____ Medicare Eligible _____ Military Leave

_____ Medical / Personal Leave _____ Disability

_____ Death

Group Administrator Signature Date

Form should be faxed to 919-719-1105 or mailed to:
County Health Plan
215 North Dawson Street
Raleigh, NC 27603
Phone: 1-866-237-9163