NOTIFICATION OF TERMINATION FOR HEALTH BENEFITS

It is extremely important that this form is completed and faxed to the Employee Benefits Division in a timely manner. This form is essential to ensure that non-covered employees and dependents do not receive State subsidized benefits. Efforts will be made to collect State subsidized premiums for employees and dependents that are no longer eligible for the State subsidized benefits.

NOTE: **Please do not send a Notice of Termination form for an employee who is transferring to another State of Maryland agency.**

TO: Office of Personnel Services and Benefits
Employee Benefits Division

FROM: _____
Agency Appointing Authority/Designee

PLEASE REMOVE THIS EMPLOYEE FROM YOUR RECORDS

Name:_____ Social Security Number:_____

Agency Code as it appears on MS 310:_____Date of Birth:_____

Applicable check distribution code:_____

Last day on payroll (last day worked):_____

Check one box in each of the following columns:

Termination Reason

- ☐ Terminated
- ☐ Resigned
- ☐ Deceased - Date: _____
- ☐ Retired - Date:_____

Employee Type

- ☐ Active
- ☐ Contractual

APPROVAL:

_____ _____
Print Name of Appointing Authority/Designee Date

_____ _____
Signature of Appointing Authority/Designee Date

FAX THIS FORM TO: (410) 333-7122

Agency FAX#_____ Agency PHONE#_____

Rev 12/2009