

## **NOTICE – Termination/Waiver**

TO:	Starr	nark Administration E	Department				
E-MAIL:	starmarkadmin@starmarkinc.com			FAX NO.:	847.6	15.5885	
RE:	Group Name			Group No			
The member w	rill rem	ain covered until the e case of disability.	ember terminates emplend of the month in COBRA, state continarticipating Employer	which terminat uation or conve	ion occur ersion mu	s or until the end of ust be offered when	
Member's Name		Member's I.D. No.	Last Date of Employment	First Date of Disability		Expected Return Date	
coverage. Plea	se be	advised when applyi	namember remains of the coverage in the law maiting periods may	ne future, the m			
			Waiving otal Coverage If Applicable	Waivin Major Medic If Applica	al Only	Waiving Dental Only If Applicable	
Member and any dependents		pendents					
Spouse							
Child(ren)							
Member's I.D.	No		Member's Name				
Effective Date	of Cha	ange	Reason for Waiver				
The member a	grees	to the above reque	est.				
	Mer	nber Signature					