



MADA
MADA INSURANCE TRUST
TERMINATION FORM

Dealership Name: _____ DIV #: _____

Employee Name: _____

SSN: _____

Employee Address: _____

City: _____ State: _____ Zip: _____

TYPE OF EVENT:

- Voluntarily Dropping Coverage:
 - Self Dependent(s) All
- Termination of Employment – Voluntary
- Termination of Employment – Involuntary/Layoff
- Retirement
- Insufficient Hours Worked
- Sick Leave
- Death of Employee
- Divorce or Legal Separation
- Dependent Ineligible or Age Limit Reached

COVERAGE(S) AFFECTED:

- MADA Dental
- Guardian Dental
- Guardian Optional Life
- Guardian Basic Life
- Guardian Short-Term Disability
- Any and All Coverages through MADA

Date of Event: _____

Date Coverage Will End (end of a month): _____

**Please provide the following information for each insured dependent who will lose coverage:
 (Complete the address information if different from employee's address)**

Dependent's Name: _____ Relationship: _____

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Dependent's Name: _____ Relationship: _____

Dependent's Name: _____ Relationship: _____

Dependent Address (if different from employee): _____

City: _____ State: _____ Zip: _____

This termination form must be received by MADA within 30 days of the termination event. To minimize billing adjustments, please submit this paperwork before the 15th of the month before the next billing cycle.

If the reason for lost coverage is a qualifying event for COBRA continuation or Missouri continuation rules, additional continuation election forms will be sent to employee's or dependent's home address. Please verify the home address(es) before submitting this form to MADA. **Mail to MADA Insurance Trust, P.O. Box 1309, Jefferson City, MO 65102, or fax to 573-636-5834.**

Employee Signature: _____ Date: _____