SMALL BUSINESS Association of MICHIGAN

FORM SBAM 01

NOTICE TO TERMINATE/CANCEL INDIVIDUAL'S COVERAGE

PLEASE COMPLETE AND RETURN TO:

To: Small Business Association of Michigan

101 S. Washington Square, Suite 900
Lansing, MI 48933 Lansing, MI 48933
MemberCare@sbam.org

Phone Number: (877) 949-7226

From: Group Name: _____ **CID#:** _____

Group Number: _____ **/SBAM Number** _____ **SBAM Administering COBRA? Yes**_____ **No**_____

Coverage Terminations/Cancellations

Subscriber Name	Contract Number (SS #)	Last Date of Coverage	Please check the coverage terminated for each subscriber				Please check the reason for termination of the subscriber			
			Life	STD	LTD	Other	Left Employment	Retired	Death	Other (please explain)
1		/ /								
2		/ /								
3		/ /								
4		/ /								
5		/ /								

Reminders

1. **Please send appropriate insurance carrier(s) forms (including BCN)**
2. **Termination of coverages will be effective as of the date given above**
3. **Notice of termination must be received within 30 days of event or full credit may not be given by insurance carrier**

Signature: _____ **Date:** _____

(Person responsible for employee records)

Rev 10/23

This form may be duplicated as required