Notice To Terminate / Cancel Individual's Insurance Coverage

SMALL BUSINESS Association of MICHIGAN

Company Name

Company Tax ID

Company Contact Person (First and Last Name)

Company Contact Person Email

☐ **Check this box if SBAM Administers COBRA for your Company.**

Please send completed forms to:

SBAM Member Care
sbam.org/membercare
membercare@sbam.org
(800) 362-5461

Important Reminders

Please send appropriate insurance carrier(s) forms (including BCN).

Termination of coverages will be effective as of the date given above.

Notice of termination must be received within 30 days of event or full credit may not be given by insurance carrier.

			Check the coverage(s) terminating for each subscriber.					Check the reason for termination for each subscriber.			
Subscriber First and Last Name	Contract Number (SS #)	**Last Date of Coverage**	**Health Dental Vision**	**Life AD&D**	**Short Term Disability**	**Long Term Disability**	**Other Coverage**	**Left Employment**	**Retired**	**Death**	**Other (please explain)**
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Signature of Person Responsible for Employee Records

Date

Printed Name

Title

This form may be duplicated as required.
Rev 07/2026