

Notice To Terminate / Cancel Individual's Insurance Coverage



Company Name

Company Tax ID

Company Contact Person (First and Last Name)

Company Contact Person Email

Please send completed forms to:

SBAM Member Care
sbam.org/membercare
(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 this box if SBAM Administers COBRA for your Company.

			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)

Signature of Person Responsible for Employee Records

Date

Printed Name

Title

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