

# EMPLOYEE TERMINATION NOTICE

\_\_\_\_\_  
Please print your Club's Name

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City, State, & Zip Code

\_\_\_\_\_  
Name of Club Contact Person

\_\_\_\_\_  
Phone Number (including area code)

**Please terminate the following individual's B&GCWA Insurance coverage:**

\_\_\_\_\_  
Employee's Name

\_\_\_\_\_  
Last Day Worked

\_\_\_\_\_  
Employee's most current address

\_\_\_\_\_  
Signature of Authorized Individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

**Please check all that apply to the above named individual:**

## Reason(s) for Termination of Insurance Benefits

<input type="checkbox"/>	Termination of Employment	<input type="checkbox"/>	No longer a Full Time Employee
<input type="checkbox"/>	Loss of Dependent Student Status	<input type="checkbox"/>	Divorced
<input type="checkbox"/>	Deceased	<input type="checkbox"/>	No longer wishes to receive coverage

Please mail or fax this form to:

**BGCWA Insurance Trust  
CTI Administrators  
100 Court Avenue, Suite 306  
Des Moines, IA 50309-2295  
Fax # (515) 244-8650**