

**Form must be completed entirely for all terminations including life only.**

**Please submit via secure email to Illinois School Insurance Network**

**[mwil.isinadministration@marshmma.com](mailto:mwil.isinadministration@marshmma.com)**

## Employee Information

District Name:	Dixon Public Schools 170	Social Security #:	—	—
Employee Name:		Date of Birth:	—	—
Address:		Telephone #:	—	—
City, State, Zip:		Gender:	<input type="checkbox"/> M	<input type="checkbox"/> F

Event Date:	/	/
<i>NOTE: Coverage will terminate at the end of the month in which the termination event occurs.</i>		
Reason for Termination:	<input type="checkbox"/> Left Employment <input type="checkbox"/> Other Coverage <input type="checkbox"/> Ineligible Child <input type="checkbox"/> Involuntary Termination <input type="checkbox"/> Death <input type="checkbox"/> Other   Describe: _____ <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Retirement	

## List Individuals Terminating from Coverage (include employee if terming)

Name	Social Security #	Birth Date	Gender	Relationship
	— —	— —		
	— —	— —		
	— —	— —		
	— —	— —		
	— —	— —		

## Current Benefits - Terminate Coverage for:

Plan	Coverage	Plan	Notes
Medical Insurance BCBS of IL	<input type="checkbox"/> Single	<input type="checkbox"/> P13957 Tier 2 PPO	
	<input type="checkbox"/> Empl +1	<input type="checkbox"/> P13955 Tier 3 PPO	
	<input type="checkbox"/> Family	<input type="checkbox"/> No coverage	
Dental Insurance MetLife	<input type="checkbox"/> Single	<input type="checkbox"/> 31535 DPPO	
	<input type="checkbox"/> Empl +1	<input type="checkbox"/> No coverage	
	<input type="checkbox"/> Family		
Vision Insurance VSP	<input type="checkbox"/> Single	<input type="checkbox"/> 30060796 Vision Plan	
	<input type="checkbox"/> Empl +1	<input type="checkbox"/> No coverage	
	<input type="checkbox"/> Family		

*Non-Affiliation benefit—not administered by LAA.  
District contact responsible for administration.*

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Terminate Life Insurance:  Yes  No      Last FSA Deduction: \_\_\_\_\_  N/A

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_