

# TERMINATION / TRANSFER REPORT

Group Number

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Please use a separate form for each subgroup.

GROUP NAME	DATE SUBMITTED
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SUBSCRIBER NAME	SUBSCRIBER SOCIAL SECURITY NUMBER	FAMILY ACCOUNT NUMBER	EFFECTIVE DATE	REASON (Circle One)								IF TRANSFER, TRANSFER TO GROUP	CHECK IF TRANSFER TO COBRA	
				TT	TI	TL	TQ	TX	TZ	T3	TI			
				1	2	3	4	5	6	7	8	Other _____	-	<input type="checkbox"/>
				1	2	3	4	5	6	7	8	Other _____	-	<input type="checkbox"/>
				1	2	3	4	5	6	7	8	Other _____	-	<input type="checkbox"/>
				1	2	3	4	5	6	7	8	Other _____	-	<input type="checkbox"/>
				1	2	3	4	5	6	7	8	Other _____	-	<input type="checkbox"/>
				1	2	3	4	5	6	7	8	Other _____	-	<input type="checkbox"/>
				1	2	3	4	5	6	7	8	Other _____	-	<input type="checkbox"/>

**TERMINATION REASON**

- 1 - Employment Terminated (TT)
- 2 - Subscriber Deceased (TE)
- 3 - Layoff/Leave of Absence (TL)
- 4 - Retired (TQ)
- 5 - Changed Insurance Carriers (TX)
- 6 - Never Eligible - Enrolled in Error (TZ)
- 7 - COBRA Time Limit Reached (T3)
- 8 - Transferred to Another Group Number (TI)

**PLEASE SEND MEMBERSHIP FORMS TO:**

**KAISER FOUNDATION HEALTH PLAN, INC.  
P.O. BOX 23250  
SAN DIEGO, CA 92129-3250**

*Please submit membership changes and forms on a daily basis.*