



ClaimLinx
 10260 Alliance Road
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 Cincinnati, OH 45242
 (513) 677-6262 or (800) 858-1772 Phone
 (513) 677-6263 or (800) 858-1913 Fax
 www.claimlinx.com

Benefit Administration That's Personal!

MERP Termination Form

Today's Date _____

This request is for termination of the following employee and/or family members for the following coverages:

(Please check all that apply:)

- Medical Dental Prescription Ortho Vision

This termination is to be effective as of _____
(this date usually coincides with termination of major medical/primary benefits)

Employee Name: _____
(first name, middle initial, last name)

Employee SS# _____ Employee Date of Birth: _____

Term Employee and ALL dependents? _____ YES Remove Dependents only? _____ YES

Term Dependent #1: _____

Term Dependent #2: _____

Term Dependent #3: _____

Term Dependent #4: _____

Company Official Signature: _____

Printed Name: _____

Company Name: _____

Company Address: _____

City, State, Zip Code: _____

**Please fax and/or mail this letter to Your Agent and ClaimLinx:
 Phone: 513- 677-6262 or 1-800-858-1772
 Fax: 513-677-6263 or 1-800-858-1913
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 Suite 130
 Cincinnati, OH. 45242**