



**EMPLOYEE HEALTHCARE  
TERMINATION FORM**

**Current Date:** \_\_\_\_\_

**Client Name:** \_\_\_\_\_

**Contact:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Employee Name:** \_\_\_\_\_

**Employee Address:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_

**Date of Termination:** \_\_\_\_\_

**Date Healthcare Coverage Ends:** \_\_\_\_\_

**Last Date of Pay:** \_\_\_\_\_

**Reason for Termination:** \_\_\_\_\_

**Comments:** \_\_\_\_\_

**Form Prepared By:** \_\_\_\_\_

**PLEASE FAX TO GMS, INC. ATTENTION LAURA OLEKSA**

**216-573-6917**