HEALTH CARE AUTHORITY

Notification to Terminate Benefits Due to Non-Payment

Employee Name:_____ **Employee ID#:** _____

Termination of Benefits Effective Date: _____

(***Termination date is based on the last PPE where the premiums were collected by employee via self-pay or payroll deduction)***

Reason for Termination: SELECT ONE

Employee Benefits to be Terminated:

Medical: SELECT ONE **Tier:** SELECT ONE

Dental: SELECT ONE **Tier:** SELECT ONE

Vision: SELECT ONE **Tier:** SELECT ONE

Disability: SELECT ONE

Employee Supplemental Life:

SELECT ONE

Dependent Spouse/DP Life:

SELECT ONE

Dependent Child(ren) Life:

SELECT ONE

- EASI Gov please contact carriers to retro term benefits.

HR Contact Name:_____ Phone Number: _____

Agency Name:_____ Date: _____

Authorized Signature: _____

E-Mail or Fax To: EASI Gov, Inc.
E-mail: sonm@easitpa.com
Fax: (505)244-6009

CC: shb.Benefits-refund@HCA.nm.gov

How to Electronically Sign: Click on Tools on the top left corner, in right window pane click Fill & Sign, Click Sign icon  ***in top window pane, select signature, and drag and place in desired area.***