TERMINATION OF COVERAGE

Do not use this form to drop dependents or to change an employee's status from active to retired; for those changes, please have the employee complete a MUST Change Form. Please fax completed form(s) to Montana Unified School Trust: (406) 442-4161

School District Name:	**Group No:**		
Employee Full Name and Last Know Address	**LAST 4 OF SSN #**	**Date of Termination***	**Termination Reason****
Full Name: Address: City: State: ZIP:			
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***Date of Termination:** The exact date the employee became ineligible for coverage. (i.e., last date employee worked as an eligible employee or the last day the employee is eligible for coverage per the terms of the employment contract). All coverage terminations are effective at the end of the month.

****Termination Reason:** For example: resigned, terminated, RIF, hourly reduction (ineligible), or death. **In the case of gross misconduct,** the employee is ineligible for COBRA. MUST does not determine gross misconduct.

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FOR MUST USE ONLY: Date Entered ____/____/____

NOTES: ____________________Q/A INIT___________