Trustmark
LIFE INSURANCE COMPANY

# EMPLOYEE TERMINATION LISTING

Group Name _____ Group # _____

Please use this form to completely terminate an employees coverage. Send this listing to us by the first of the month and these terminations will be included on your next month's billing statement.

| Employee Name | Social Security #/ID | Last Date of Full-Time Employment | COBRA Termination Date |
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**In order to facilitate accuracy on your statement, please pay the statement as billed.**

These terminations have been authorized by:

Name _____ Date _____

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