NORTHERN ILLINOIS UNIVERSITY
Human Resource Services

Request for Termination of State of Illinois Insurance Coverage

Employee Name: ___________________________________

Employee ID: ______________________________________

Date of Coverage Termination: _______________________

***The effective date of coverage termination will be the end date of your current contract if the form is received by Human Resource Services prior to the end date of your current contract.**

***The effective date of coverage termination will be the first day of the next pay period if the form is received by Human Resource Services after the end date of your current contract.**

***This form can only be used by those temporary employees that will not have a Fall contract issued or who have resigned their position.**

Employee Signature: ______________________________

Date of Request: __________________________________

<u>For Employer Use Only</u>

Confirmed Separation with Employment: ________________________________

Effective Date of Separation: ____

Entered in PS by: ____

Date Entered in PS: ____

Entered in CMS by: ____

Date Entered in CMS: ____