



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:

Employee Benefits to be Terminated:

Medical:

Tier:

Dental:

Tier:

Vision:

Tier:

Disability:

Employee Supplemental Life:

Dependent Spouse/DP Life:

Dependent Child(ren) Life:

 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.

Health Care Authority / State Health Benefits

Physical Address:

1474 Rodeo Rd.

Santa Fe, NM 87505

Mailing Address:

P.O. Box 2348

Santa Fe, NM 87504-2348