Employee Termination Report

Group Premium and Enrollment Services

Mutual of Omaha

Date _____

Employer's Company Name _____

Address _____

Sub-Group Name _____ Location Code _____

Group I.D. _____ Sub-Group I.D. _____

Please list below the names of those employees who are no longer employed by your firm and no longer eligible for coverage. This form may be returned separately or attached to your remittance for any credit due your account. If changes are not received within five working days of the date your billing statement is produced, the changes will appear on your subsequent billing statement. Please submit your terminations immediately. If applicable, credit will be limited according to your master policy/contract.

Soc. Sec. No.	Employee's Name	Day Last Worked*	Reason

*If coverage ends other than "Day Last Worked," please give the date of coverage should end and explanation in "Reason" column.

Prepared By _____

MUG6582