MEMBER TERMINATION FORM

Please complete all information on this form. This information is required to process your disenrollment.

GROUP INFORMATION

Employer group name:	Group number:
Requested termination date:	Member ID Number
Plan Name:	☐ Vision

TERMINATION INFORMATION

❑ Employee	❑ Spouse	❑ Dependents

❑ Last day of full-time employment:___/_____/_____

Reason for termination. Employee no longer eligible. Please Explain (Check one):

❑ Loss of Employment	❑ Reduction in hours	❑Loss of dependent status	❑ Medicare eligibility

❑ Other Coverage	❑Death	❑Marriage	❑ Divorce	❑ Other: _____

EMPLOYEE INFORMATION

Last name:	First name:	Middle initial:	❑ Mr. ❑ Mrs. ❑ Ms.
Birth date (mm/dd/yyyy):	Sex: ❑ Male ❑ Female		
Address:		Phone:	

DEPENDENT INFORMATION

First name	Last name	Middle initial	Relationship to employee	Birth date	Gender (m/f)

EMPLOYER SIGNATURE

Signature:	Printed Name:	Date

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