



PacAdvantage

Choice • Simplicity • Affordability

MEMBER TERMINATION FORM

EMPLOYER INFORMATION

Group number

Name of employer

MEMBER INFORMATION

If disenrolling an employee with or without dependents, please enter the employee's name and social security number. If disenrolling a dependent only, enter the dependent's name and social security number. If disenrolling more than one dependent from your employee's coverage, use one form for each dependent.

Member last name

M.I.

Member first name

Social security number

____ - ____ - _____

Terminate coverage as of (date cannot be more than 30 days prior to the date that this form is received by the program):

____ / ____ / _____

REASON FOR TERMINATION

Terminated employment as of date

____ / ____ / _____

Obtained other coverage

Employee request (for reasons other than above)

Employee no longer eligible (.E. reduction in hours, moved out of service area, etc.)

Dependent no longer eligible

Other (please specify):

Employer authorized representative last name

Employer authorized representative first name

Signature of employer / authorized representative

Signature

Date signed

____ / ____ / _____