Member Cancellation of Coverage Form

Submit at least 3 business days prior to end of the month.
Please print or type in black or blue ink only.

Company name

Cancellation date (covered until last day of month) ___/___/___

Group no.

Name of subscriber

Member id

CANCELLATION FOR *(check one)*

☐ Subscriber and dependents ☐ Dependent(s) only

If canceling dependents only, please list names and dates of births of dependents to be canceled:

Name of dependent ____ Date of birth ____ Name of dependent ____ Date of birth ____

Name of dependent ____ Date of birth ____ Name of dependent ____ Date of birth ____

Name of dependent ____ Date of birth ____ Name of dependent ____ Date of birth ____

REASON FOR CANCELLATION *(check one)*

☐ Voluntary termination of employment ☐ Involuntary termination of employment ☐ Divorce

☐ Group coverage through spouse ☐ Deceased

☐ Other ____

WHEN FORM IS COMPLETED BY EMPLOYEE:

By canceling group coverage, I understand that neither I nor my dependents can re-enroll on this group policy until the next open enrollment period or after a qualifying event.

Employee/subscriber signature ____ Date ____

WHEN FORM IS COMPLETED BY EMPLOYER:

By canceling group coverage, I understand that neither the employee nor his/her dependents can re-enroll on this group policy until the next open enrollment period or after a qualifying event.

Employer contact name (print) ____ Employer contact signature ____ Date ____

TO SUBMIT THIS FORM:

Employer: Submit signed and completed form to our Customer Service team
by email: **support@decent.com**
by fax: **512-729-7178**