



Benefit Cancellation Form

Today's Date: _____

Employer Name: _____

Bene-Care Account #: _____

Name of Subscriber: _____

Coverage(s) to be cancelled:

- Medical
- HRA/FSA
- Dental
- Life Insurance
- Vision
- Other _____

Effective date of cancellation: _____

Reason for cancellation (check at least one):

- Terminated from employment
- Laid off
- Quit
- No longer eligible for benefits
- Divorce/legal separation
- Dependent deceased
- Other (please specify): _____
- Subscriber request
- Changed to spouse's plan
- Subscriber deceased
- Medicare eligibility

Cancel Dependent(s) Only (name all dependents to be cancelled):

Employer Signature: _____

- Please send COBRA information
- COBRA information not necessary