

# Bene-Care Agency, LLC Benefits Advocate

## 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