Today's Date: _____

Bene-Care
Insurance ▪ Payroll ▪ HR Solutions

Employee/Individual Benefit Cancellation Form

*Please note: Individuals requesting to terminate/change coverage with Excellus or Univera are required to submit a carrier specific form.

Employer Name: _____

Bene-Care Account #: _____

Name of Subscriber: _____

Subscriber ID #: _____

Coverage(s) to be cancelled:

- ☐ Medical
- ☐ Vision
- ☐ FSA
- ☐ Payroll
- ☐ Dental
- ☐ HRA
- ☐ Life Insurance
- ☐ Other_____

Last Day of Employment: _____

Benefit Cancellation Date: _____

Reason for Cancellation (must check at least one):

Involuntary

- ☐ Termination of Employment
- ☐ Laid Off
- ☐ Reduction of Hours – No longer benefit eligible
- ☐ Divorce/Legal Separation

Voluntary

- ☐ Dependent Aged Off
- ☐ Left Employment – Quit
- ☐ Changed to Spouse's Plan
- ☐ Medicare Eligibility
- ☐ Subscriber Request

Other

- ☐ Subscriber Deceased
- ☐ Dependent Deceased
- ☐ Cancel Dependent(s) Only (name all dependents to be cancelled)

_____

_____

Employer/Subscriber Signature: _____