Bene-Care
Benefits, Payroll, HR Solutions

Personal ▪ Proactive ▪ Powerful

Today's Date: _____

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:

O Medical O HRA O Payroll O Vision

O Dental O FSA O Life Insurance O Other _____

Last Day of Employment: _____

Benefit Cancellation Date: _____

Reason for cancellation (check at least one):

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

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

_____

_____

O Please send COBRA information O COBRA information not necessary

Employer/Subscriber Signature: _____