

# Cancellation Request

## Part A – To be completed by the employer

Group name \_\_\_\_\_

Name of employee \_\_\_\_\_

Birth date \_\_\_\_\_ Agreement number \_\_\_\_\_

Current address \_\_\_\_\_  
Street City State ZIP

Plan  GroupCare/self-funded  Congregational Employee Plan

If you are canceling an employee, please complete Part B. We will cancel all the employee's participating family members unless you instruct us otherwise.

If an employee is canceling a participating family member, he or she will need to complete Part C.

## Part B – To be completed by the employer if you are canceling an employee and his or her participating dependents

Last day actively at work \_\_\_\_\_ Date of cancellation\* \_\_\_\_\_

Reason for cancellation

Loss of coverage due to termination of employment

Voluntary  Involuntary

Reduction in hours to ineligible status

Death

Medicare entitlement

Other \_\_\_\_\_

Coverage currently enrolled in (check all that apply)

Medical

Dental

FlexChoice

Special instructions \_\_\_\_\_

\_\_\_\_\_  
Signature of group representative

\_\_\_\_\_  
Date

## Part C – To be completed by the employee if canceling a participating family member

Person(s) to be canceled from all current plans:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address (if different than indicated in Part A above) \_\_\_\_\_  
Street City State ZIP

Reason for cancellation:

Divorce/legal separation

Dependent no longer meets eligibility requirements

Other \_\_\_\_\_

Date of cancellation\* \_\_\_\_\_

\_\_\_\_\_  
Signature of employee

\_\_\_\_\_  
Date

### Everence Association, Inc.

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*\*In Congregational Employee Plan, cancellations are effective the last day of the month in which the individual no longer qualifies for coverage. In GroupCare, see your summary plan description.*