Instructions: This form can be completed on screen. The TAB key will move from field to field. After completion you may print the form and fax it or click on the "Submit by Email" button to send from your desktop email manager (i.e. Thunderbird, Outlook, etc). If you prefer, you may print a blank form, complete it and submit it to BSI.

Print Form

Submit by Email

Group Benefit Plan
Notice of Participant Termination

Company Name

Employee ID

Insured Last Name

First Name, MI

If the terminated participant is not the insured, please indicate below the dependent to be terminated.

Dependent Full Name — Relationship

Dependent Full Name — Relationship

Dependent Full Name — Relationship

Dependent Full Name — Relationship

Terminate ALL coverages ☐

or

Please check coverages which are being terminated... ☐ Medical ☐ Dental ☐ Vision

Reason for termination: Termination of Employment

If Termination of employment

☐ In-Voluntary

☐ Voluntary

Please enter the effective date of the coverage termination (mm/dd/yyyy)

Submitted by

Date Submitted

Benefit Solutions, Inc. PO Box 385 Taylorsville, NC 28681 828.632.4970 Fax 828.632.4969 www.benefitsus.com