



Benefit Advantage

Mail: PO BOX 5545 DePere, WI 54115-5545
Phone: (800) 686-6829
Fax: (920) 339-0038

TERMINATION REQUEST FORM

Name: _____ Social Security Number: _____

Former Employer: _____

Please complete this request in its entirety. The completed Termination Request Form must be **received** on or before the 25th day of the month in which you wish to terminate coverage (Example: To terminate coverage effective 08/01, the completed Termination Request Form must be received by Benefit Advantage no later than 8/25). Any request received after this date, may result in a revised termination date. If applicable, Benefit Advantage will only refund premiums received in the current month or applied to the current premium month.**

1. Please indicate below which coverage(s) you would like to terminate:

- Medical
- Dental
- Vision
- Other: _____
- All of the above

2. I would like my coverage(s) to terminate effective: _____ / _____ / _____

3. Reason for Termination of Coverage(s):

- Other Coverage (*Benefit Advantage reserves the right to require Proof of Other Coverage*)
- Medicare Eligible
- Other: _____

**ALL covered participants age 18 or older, who want to terminate their coverage are required to sign this request
If all required signatures are not present, Benefit Advantage will return your request and will not terminate coverage.**

Covered Participant(s) to term coverage:	Signature of Covered Participant(s): <small>(required for all participates 18 years and older)</small>	Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Return the completed form to Benefit Advantage:

Mail to: PO BOX 5545 DEPERE, WI 54115	Fax to: (920) 339-0038 Email to: COBRA@benadvan.com
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In the event you email your completed request to Benefit Advantage and do not receive a confirmation response, please resubmit and verify that Benefit Advantage has received your communication

****Initial Premium Payment will not be refunded, if the Reinstatement Notice has already been sent to your insurance carrier.**