



Termination/Involuntary Loss of Coverage

Mail or fax this form immediately to:
HospitalityCARE, P.O. Box 6702, Columbia, SC 29260-6702
Fax (803) 264-0772

When Terminating All Benefits:

Employee must:

- Sign and date Section 5, if available.

Company Representative must:

- Complete Sections 1, 2, 3 and sign and date Section 4.
- Submit completed form to HospitalityCARE within five days of employee termination.

Questions? Call HospitalityCARE at (888) 583-3057

Section 1.

Employee's Name: _____ SSN: _____
Last First Middle

Address: _____
Street City State ZIP

Group Number: _____ Effective Date of Termination: _____
(The effective date of termination is the last day of the pay period for which premiums were deducted.)

Section 2. Reason for Termination (Check one and enter the date requested.)

- Termination of Employment Last Day Worked: ____/____/____
 Death of Employee Date of Death: ____/____/____
 Reduction of hours Last Day Worked: ____/____/____
 Loss of Dependent Coverage Date of Coverage Loss: ____/____/____
 Divorce/Legal Separation Date of Divorce/Separation: ____/____/____

Section 3. List all family members to be cancelled

Dependent Names (First and Last)	Address (if different from address above)
Name _____	Street _____ City _____ State _____ ZIP _____
Name _____	Street _____ City _____ State _____ ZIP _____
Name _____	Street _____ City _____ State _____ ZIP _____
Name _____	Street _____ City _____ State _____ ZIP _____

Section 4.

Authorized Company Representative: _____ Date: _____
Please print name: _____ Telephone: (____) _____ - _____
(Please include area code.)

Section 5.

Employee Signature (if available): _____ Date: _____