VADA TERMINATION OR VOLUNTARY CANCELLATION FORM

Employee's Last Name:

Group Name:	BCBSVT Group No. & Division No.:	NEDD Group No:	DeltaVision Group No:

REASON FOR TERMINATION

Voluntary Termination of Employment   Involuntary Termination of Employment

Transfer to VADA Member ______________________________

Death of Employee   Reduction in Hours   N/A

Termination Date/Last Day Worked:

Effective Date: *VADA Use Only*

STILL EMPLOYED - Voluntary Cancel by Employee *To remove dependents only from coverage please complete a Group Enrollment/Change Form*

Medical Only   Dental Only   Vision Only   Medical, Dental & Vision

Employees Signature: ____   N/A

Cancellation Date:

Effective Date: *VADA Use Only*

	Name:	Gender:	SSN:	Date of Birth:
Subscriber:				
Spouse:				
Child #1:				
Child #2:				
Child #3:				
Child #4:				

Rec'd by VADA:

Mailing Address:	**City:**	**State:**	**Zip:**

BENEFITS TO BE TERMINATED OR CANCELLED

Health Plan: A B C D E F N/A | **Plan Type:** Single 2 Person Family N/A

Dental Plan: Yes N/A | **Plan Type:** Single 2 Person Family N/A | **Disability:** Yes - 60% to $300 N/A

Vision: $130 $180 N/A | **Plan Type:** Single 2 Person Family N/A | **Life:** $5K $10K $15K $25K $50K N/A

Group Signature:	Date Submitted: