

**VADA TERMINATION/CANCELLATION FORM**

Insured's Last Name

\_\_\_\_\_

Group Name: \_\_\_\_\_

BCBSVT Group No: \_\_\_\_\_

NEDD Group No: \_\_\_\_\_

This form is for: \_\_\_\_\_ COBRA (groups >20 employees\*) \_\_\_\_\_ VIPER (groups <20 employees\*)

*\*To count the actual number of employees please use the total currently on payroll. This is not just the number of insureds.*

**Qualifying Event:**

**Date of Event:** \_\_\_\_\_

- \_\_\_\_\_ *Voluntary* Termination of Employment
- \_\_\_\_\_ *Involuntary* Termination of Employment
- \_\_\_\_\_ Reduction in Hours
- \_\_\_\_\_ Disability
- \_\_\_\_\_ Death of Employee
- \_\_\_\_\_ Retirement
- \_\_\_\_\_ Loss of Dependent Status

- \_\_\_\_\_ Medicare Eligibility
- \_\_\_\_\_ Divorce/Legal Separation
- \_\_\_\_\_ Armed Services Deployment
- \_\_\_\_\_ Voluntary Cancel\*:
- \_\_\_\_\_ Medical only
- \_\_\_\_\_ Dental only
- \_\_\_\_\_ Medical and Dental

\* \_\_\_\_\_  
*Employee Signature*

Name Employee: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Name Spouse: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Name Child #1: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Name Child #2: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Name Child #3: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

**Current Benefits:** *(please check all appropriate boxes)*

Health Plan: \_\_\_\_\_ **A** \_\_\_\_\_ **B** \_\_\_\_\_ **C**  
 \_\_\_\_\_ **D** \_\_\_\_\_ **E** \_\_\_\_\_ **F**

Health Membership Type: \_\_\_\_\_ Single \_\_\_\_\_ 2-Person \_\_\_\_\_ Family

Dental Plan: \_\_\_\_\_ Plan I \_\_\_\_\_ Plan II

Dental Membership Type: \_\_\_\_\_ Single \_\_\_\_\_ 2-Person \_\_\_\_\_ Family

Disability: \_\_\_\_\_ 60% to \$ \_\_\_\_\_ \_\_\_\_\_ 66 2/3% to \$ \_\_\_\_\_

Group Contact: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Date: \_\_\_\_\_

