



# VADA TERMINATION OR VOLUNTARY CANCELLATION FORM

Employee's Last Name: \_\_\_\_\_

Group Name:	MVP Group #	NEDD Group No:	DeltaVision Group No:
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## 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: <i>VADA Use Only</i>
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## 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 <i>Employees Signature:</i> _____      N/A	Cancellation Date:  Effective Date: <i>VADA Use Only</i>
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<b>Subscriber:</b>	Name:	Gender:	SSN:	Date of Birth:
<b>Spouse:</b>	Name:	Gender:	SSN:	Date of Birth:
<b>Child #1:</b>	Name:	Gender:	SSN:	Date of Birth:
<b>Child #2:</b>	Name:	Gender:	SSN:	Date of Birth:
<b>Child #3:</b>	Name:	Gender:	SSN:	Date of Birth:
<b>Child #4:</b>	Name:	Gender:	SSN:	Date of Birth:
<b>Mailing Address:</b>		<b>City:</b>	<b>State:</b>	<b>Zip:</b>

Rec'd by VADA:

## BENEFITS TO BE TERMINATED OR CANCELLED

<b>Health Plan:</b>	A	B	C	D	E	F	N/A	<b>Plan Type:</b>	Single	2 Person	Family	N/A							
<b>Dental Plan:</b>	Yes		N/A					<b>Plan Type:</b>	Single	2 Person	Family	N/A	<b>Disability:</b>	Yes - 60% to \$300	N/A				
<b>Vision:</b>	\$130	\$180	N/A					<b>Plan Type:</b>	Single	2 Person	Family	N/A	<b>Life:</b>	\$5K	\$10K	\$15K	\$25K	\$50K	N/A

Group Signature:	Date Submitted:
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