VADA TERMINATION OR VOLUNTARY CANCELLATION FORM

Employee's Last Name

Group Name:	BCBSVT Group No: & Division No.	Northeast Delta Dental 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

Date of Event:
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: ☐ Plan 2 ☐ N/A — **Plan Type:** ☐ Single ☐ 2 Person ☐ Family ☐N/A — **Disability:** ☐ 60% to $200 ☐ 60% to $200 ☐ N/A

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

Group Signature:	Date Submitted:

PRINT CLEAR