



Termination/Involuntary Loss of Coverage

Mail or fax this form to:
PAI, P.O. Box 6702, Columbia, SC 29260-6702
Fax (803) 870-8060

When Terminating All Benefits:

Company Representative must:

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

Questions? Call Customer Service (866) 798-0803.

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.)

- | | | |
|---|--|---|
| <input type="checkbox"/> Termination of Employment
Last Day Worked: _____ | <input type="checkbox"/> Death of Employee
Date of Death: _____ | <input type="checkbox"/> Reduction of hours
Last Day Worked: _____ |
| <input type="checkbox"/> Loss of Dependent Coverage
Date of Coverage Loss: _____ | <input type="checkbox"/> Divorce/Legal Separation
Date of Divorce/Separation: _____ | |

Section 3. List all family members to be cancelled. (Also add dependent address if not residing with employee.)

<i>Dependent Names (First and Last)</i>	<i>Address (if not residing with employee)</i>
_____ 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 Signature: _____ Date: _____

Please Print Name: _____ Telephone: _____
(Please include area code.)

Section 5.

Employee Signature (if available): _____ Date: _____

Questions? Call Medical StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.