MSC MEDICAL STAFFCARE

# 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.)

☐ Termination of Employment
Last Day Worked: _____

☐ Death of Employee
Date of Death: _____

☐ Reduction of hours
Last Day Worked: _____

☐ Loss of Dependent Coverage
Date of Coverage Loss: _____

☐ 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.)

*Dependent Names (First and Last)* *Address (if not residing with employee)*

| Name | Street | City | State | ZIP |
|---|---|---|---|---|
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## 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.