Hawaii Dental Service
TERMINATION FORM

HDS Use Only

Date Processed	Processed By

A. Group Information

To be completed by the Group Administrator — PLEASE PRINT LEGIBLY

Group / Division # ____ / ____ Group Name

Contact Name Contact Phone # ___ - ___ - ____ ext

B. Terminate the following Eligible Employees

List Eligible Employees that are no longer eligible for benefits.

Effective Date __ / __ / 2 0 __ Social Security Number ___ - __ - ____

Name of Eligible Employee (Last Name, First Name)

Effective Date __ / __ / 2 0 __ Social Security Number ___ - __ - ____

Name of Eligible Employee (Last Name, First Name)

Effective Date __ / __ / 2 0 __ Social Security Number ___ - __ - ____

Name of Eligible Employee (Last Name, First Name)

Effective Date __ / __ / 2 0 __ Social Security Number ___ - __ - ____

Name of Eligible Employee (Last Name, First Name)

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Name of Eligible Employee (Last Name, First Name)

Effective Date __ / __ / 2 0 __ Social Security Number ___ - __ - ____

Name of Eligible Employee (Last Name, First Name)

Effective Date __ / __ / 2 0 __ Social Security Number ___ - __ - ____

Name of Eligible Employee (Last Name, First Name)

C. Authorization

I certify that the information provided is true, correct and meets the terms and conditions of the HDS Agreement.

Authorized Group Administrator Signature

Date

FORM NO. FAFMS0002 (02/08)