

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