TERMINATION FORM

Fax to: (604) 419-0299

Attention: Group Insurance Administrator

	Member ID Number	Name of Employee Last Name / First Name	Termination Date Month/Day/Year
1.		/	
2.		/	
3.		/	
4.		/	
5.		/	
6.		/	
7.		/	
8.		/	
9.		/	
10.		/	

Date: _____ Employer Signature: _____

Account #: _____ Company Name: _____