

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
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Group / Division # / Group Name

Contact Name Contact Phone # - - ext

B.	Eligible Employee's to Terminate	List Eligible Employees that are no longer eligible for benefits.
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Effective Date / / 2 0 Social Security Number - -

Eligible Employee Name (Last Name, First Name)

Effective Date / / 2 0 Social Security Number - -

Eligible Employee Name (Last Name, First Name)

Effective Date / / 2 0 Social Security Number - -

Eligible Employee Name (Last Name, First Name)

Effective Date / / 2 0 Social Security Number - -

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Eligible Employee Name (Last Name, First Name)

Effective Date / / 2 0 Social Security Number - -

Eligible Employee Name (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.
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Authorized Group Administrator Signature

Date