

# Supplemental Vision Benefit Employer Trust (SVBET)

## Termination Form

**Please complete this form to terminate coverage for an employee and/or the employee's dependents.**

Company Name		Customer #
Employee Name – Last	First	Social Security Number - -

**Terminate coverage for:**

<b>Check one:</b> <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Only <input type="checkbox"/> Spouse Only	<input type="checkbox"/> Children Only <input type="checkbox"/> One Child Only, Provide Name: _____	<b>Terminate coverage for (check all that apply):</b> <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro	<b>COBRA:</b> <input type="checkbox"/> Offer COBRA <input type="checkbox"/> Term COBRA	<b>Requested Term</b> <b>Date</b> ____ / ____ / ____
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**REASON FOR TERMINATION OF COVERAGE (check one):**

<input type="checkbox"/> Employee terminated employment. Last day of full-time employment: ____ / ____ / ____		<input type="checkbox"/> Employee no longer eligible. Please explain:			
<b>Employer Signature (in black ink)</b>		<b>Print Name</b>		<b>EMAIL ADDRESS*</b>	<b>Date</b>
<input type="checkbox"/> Other coverage	<input type="checkbox"/> Death	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Other: _____	
<b>Employee Signature (in black ink)</b>		<b>Print Name</b>		<b>EMAIL ADDRESS*</b>	<b>Date</b>

Photocopy if more forms are required

\* Email addresses are for sending confirmations only and will not be used for any other purposes.

**To submit this request:**

**Online:** Visit [www.beneficialadmin.com](http://www.beneficialadmin.com) and click on “Administer Employee Status”

**Email to:** customerservice@beneficialadmin.com

**Fax to:** Attn: Administration (949) 724-1603

**Mail to:** Beneficial Administration, LLC

PO Box 3100

Newport Beach, CA 92658-9027

Phone: (800) 854-7417