HEALTH CARE EMPLOYEES/EMPLOYER MEDICAL & DENTAL TRUST MEMBERSHIP TERMINATION REQUEST

This form must be submitted to the Health Care Employees/Employer Dental and Medical Trust for each employee within 14 days of the effective date of termination.

I. EMPLOYEE INFORMATION

Employee's Full Name	Social Security Number	Date of Birth
Address	City	State Zip

II. TERMINATION INFORMATION

TERMINATION DATE:

TERMINATION REASON:

Employer Signature	Date
Employer Printed Name	Employer Phone Number