DELTA DENTAL

HDS
Hawaii Dental Service

EMPLOYEE TERMINATION FORM

OAHU:
PHONE: 529-9230
FAX: 529-9207
TOLL FREE:
1-844-829-3256
1-866-590-7989
EMAIL: MS@HawaiiDentalService.com

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 employees:

Do not include dependents of the terminated employee.

EFFECTIVE DATE __ / __ / 2 0 __ EMPLOYEE OR HDS ID NUMBER ____ BIRTHDATE (MM/DD/YYYY) __ / __ / ____

EMPLOYEE: LAST NAME, FIRST NAME ____

EFFECTIVE DATE __ / __ / 2 0 __ EMPLOYEE OR HDS ID NUMBER ____ BIRTHDATE (MM/DD/YYYY) __ / __ / ____

EMPLOYEE: LAST NAME, FIRST NAME ____

EFFECTIVE DATE __ / __ / 2 0 __ EMPLOYEE OR HDS ID NUMBER ____ BIRTHDATE (MM/DD/YYYY) __ / __ / ____

EMPLOYEE: LAST NAME, FIRST NAME ____

EFFECTIVE DATE __ / __ / 2 0 __ EMPLOYEE OR HDS ID NUMBER ____ BIRTHDATE (MM/DD/YYYY) __ / __ / ____

EMPLOYEE: LAST NAME, FIRST NAME ____

EFFECTIVE DATE __ / __ / 2 0 __ EMPLOYEE OR HDS ID NUMBER ____ BIRTHDATE (MM/DD/YYYY) __ / __ / ____

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EFFECTIVE DATE __ / __ / 2 0 __ EMPLOYEE OR HDS ID NUMBER ____ BIRTHDATE (MM/DD/YYYY) __ / __ / ____

EMPLOYEE: LAST NAME, FIRST NAME ____

EFFECTIVE DATE __ / __ / 2 0 __ EMPLOYEE OR HDS ID NUMBER ____ BIRTHDATE (MM/DD/YYYY) __ / __ / ____

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.

Group Administrator Signature ____ Date ____