

Cypress Dental Administrators Employee Group Dental Termination Form



Please mail termination form to:

Cypress Dental Administrators
7510 Shoreline Drive, Suite A-1
Stockton, CA 95219
Fax 209-478-5614
Toll Free 800-350-3989

Group/Employer Name: _____

Employee Name: _____

Employee Certificate ID#: _____

Employee Address:

Street _____

City _____

State _____

Zip _____

Phone # _____

Email Address _____

Employee Termination Date: _____
(Last day worked or qualifying event date)

Termination Effective Date: _____
(Limited to the 1st of the month following the above termination effective date or qualifying event date not to exceed 30 days)

Please terminate the dental insurance policy for the following:

Self Only

Spouse Only

Child(ren) Only Name(s): _____

Family

Signature: _____

Date: _____

NOTICE TO EMPLOYER: If the above termination or qualifying event triggers COBRA eligibility, the Employer MUST submit an "Employer Notification of Qualifying Event Under Federal and State COBRA" form (available at www.cypressadmin.com under "Forms" tab) within 30 days of the qualifying event.