



# Termination Request

CONNECT ADMINISTRATORS

Please email this form to: [gbs.termination.notice@amwins.com](mailto:gbs.termination.notice@amwins.com) or Fax to 410.832.1316

Group Name	Submission Date
Amwins Connect Administrators Account Number	Employer Signature

**MEMBER TERMINATION OR PRODUCT TERMINATION IMPORTANT – PLEASE PROVIDE THE FOLLOWING INFORMATION FOR ALL EMPLOYEES TERMINATING EMPLOYMENT OR REQUESTING CANCELLATION OF COVERAGE/PRODUCT.**

TERMINATION EFFECTIVE DATES WILL BE PROCESSED BASED ON CARRIER GUIDELINES. IF RECEIVED AT AMWINS BY 3:00 PM THE REQUEST WILL BE PROCESSED ON DATE OF RECEIPT.

EMPLOYEE SOCIAL SECURITY NUMBER	EMPLOYEE'S NAME	EFFECTIVE DATE	PRODUCTS TO BE TERMED (MED, DEN, VIS, LIFE, ETC. OR ALL)	REASON	ADDRESS

## DEPENDENT TERMINATION OR PRODUCT TERMINATION

IF A COVERAGE LEVEL CHANGE RESULTS FROM A DEPENDENT TERMINATION, PLEASE SUBMIT A REVISED/SIGNED ELECTION FORM. SUPPORTING DOCUMENTATION MAY BE REQUIRED.

EMPLOYEE SOCIAL SECURITY NUMBER	DEPENDENT NAME	EFFECTIVE DATE	PRODUCTS TO BE TERMED (MED, DEN, VIS, LIFE, ETC. OR ALL)	REASON	DEPENDENT ADDRESS