

Termination/Involuntary Loss of Coverage

Mail or fax this form to: PAI
P.O. Box 6702, Columbia, SC 29260-6702
Fax (803) 870-8060

When Terminating All Benefits:

Company Representative must:

- Complete Sections 1, 2, 3 and sign and date Section 4.
- Submit completed form to BIC within five days of employee termination.

Questions? Call PAI customer service at (800) 740-4006

Section 1.

Employee's Name: _____ SSN: _____
Last First Middle

Address: _____
Street City State ZIP

Group Number: _____ Effective Date of Termination: _____
(The effective date of termination is the last day of the pay period for which premiums were deducted.)

Section 2. Reason for Termination (Check one and enter the date requested.)

- Termination of Employment Death of Employee Reduction of hours
Last Day Worked: _____ Date of Death: _____ Last Day Worked: _____
- Loss of Dependent Coverage Divorce/Legal Separation
Date of Coverage Loss: _____ Date of Divorce/Separation: _____

Section 3. List all family members to be cancelled

Dependent Names (First and Last)	Address (if different from address above)			
_____ Name	_____ Street	_____ City	_____ State	_____ ZIP
_____ Name	_____ Street	_____ City	_____ State	_____ ZIP
_____ Name	_____ Street	_____ City	_____ State	_____ ZIP
_____ Name	_____ Street	_____ City	_____ State	_____ ZIP

Section 4.

Authorized Company Representative: _____ Date: _____

Please print name: _____ Telephone: _____
(Please include area code.)



Plans are underwritten by Companion Life Insurance Company, Columbia, South Carolina.