Small Business Advantage

P.O. Box 26908
San Francisco, CA 94126
p: 415-989-7443
f: 415-439-5861

TERMINATION OF ENROLLEE'S COVERAGE

FOR YOUR SMALL BUSINESS ADVANTAGE DENTAL PROGRAM

Use this form if:

1. You have already prepaid dues for this enrollee.
2. It is prior to the 25th of the month in which this termination should take effect.

Group Name _____

Group Number _____ Employer Number _____

Contact Person _____

Telephone Number _____

Please Terminate _____
(Enrollee's name and Social Security Number)

Enrollee's last month of dental coverage will be _____
(no mid-month terminations allowed)

Authorizing Signature _____

Printed Name _____ Date _____

Please fax this form no later than the 25th of the month in which you would like this termination to become effective. Termination requests received after the 25th will be made effective on the following month's statement.

FAX THIS FORM TO: ALLIED ADMINISTRATORS (415) 439-5861
ATTENTION: ACCOUNT COORDINATOR