

Effective immediately, please use this form for all employee terminations!!

VISION INSURANCE PLAN OF AMERICA, INC.

P.O. Box 44077

Milwaukee, WI 53214-7077

(414) 475-1875 (800) 883-5747 Fax (414) 475-1599

TERMINATION OF COVERAGE NOTIFICATION

Today's Date _____

Group Number _____

Group Name _____

Authorized By _____

Phone Number _____

Employee Name: _____

Employee Soc Sec #: _____

Termination Date: _____

Reason For Termination of Coverage:

Ended employment with company

Open Enrollment

Qualifying Life Event

(Please note- Section 125 of the Internal Revenue Code requires that a change in coverage for a qualifying life event be consistent with the actual qualifying life event.)

Please fax this form to the enrollment department within 3 business days of employee's termination of coverage. If you have any questions regarding this form, please contact Lynn at extension 26. Thank you.

Fax # 414-475-1599

(Copy form as needed)