



PERF

PERF

CANCELLATION AUTHORIZATION FORM (2)

Return via fax to 404-894-6978



Group Name: _____ Group Number: _____

Completed By: _____ Page _____ of _____

Title: _____ Telephone: _____ Date: _____

Employee	Member No.	Last Name	First Name	MI
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Cancel employee? YES NO If yes → Coverage being Canceled Medical

Please note: Canceling the employee's coverage will cancel coverage for ALL dependents. Reason Date of Death _____ Left Employment Other Coverage

Cancel all dependents? YES NO If NO, complete the following:

Dependent Name (First, MI, Last Name)	Cancellation Effective Date*	Coverage Being Canceled
		<input type="checkbox"/> Medical
		<input type="checkbox"/> Medical
		<input type="checkbox"/> Medical

Employee signature required for dependent cancellation. _____

Employee Signature Date