

EMPLOYEE TERMINATION FORM

OAHU: TOLL FREE:
PHONE: (808) 529-9230 1-844-829-3256
FAX: (808) 529-9207 1-866-590-7989
EMAIL: MS@HawaiiDentalService.com

A. Group Information To be completed by the Group Administrator **PLEASE PRINT LEGIBLY**

Group/Division # / Group Name

Contact Name Contact Phone # - - ext

B. Terminate the following employees: Do not include dependents of the terminated employee.

EFFECTIVE DATE / / EMPLOYEE OR HDS ID NUMBER BIRTHDATE (MM/DD/YYYY) / /

EMPLOYEE: LAST NAME, FIRST NAME

EFFECTIVE DATE / / EMPLOYEE OR HDS ID NUMBER BIRTHDATE (MM/DD/YYYY) / /

EMPLOYEE: LAST NAME, FIRST NAME

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EFFECTIVE DATE / / EMPLOYEE OR HDS ID NUMBER BIRTHDATE (MM/DD/YYYY) / /

EMPLOYEE: LAST NAME, FIRST NAME

C. Authorization I certify that the information provided is true, correct and meets the terms and conditions of the HDS Agreement.

Group Administrator Signature

Date