DELTA DENTAL
HDS
Hawaii Dental Service

EMPLOYEE TERMINATION FORM

OAHU:
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1-844-829-3256
1-866-590-7989
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To ensure security and confidentiality, you must encrypt electronic files before transmitting them by email or other electronic means.

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 __ / __ / 2 0 __ Employee or HDS ID Number ____ Birthdate (MM/DD/YYYY) __ / __ / ____

Employee: Last Name, First Name ____

Effective Date __ / __ / 2 0 __ Employee or HDS ID Number ____ Birthdate (MM/DD/YYYY) __ / __ / ____

Employee: Last Name, First Name ____

Effective Date __ / __ / 2 0 __ Employee or HDS ID Number ____ Birthdate (MM/DD/YYYY) __ / __ / ____

Employee: Last Name, First Name ____

Effective Date __ / __ / 2 0 __ Employee or HDS ID Number ____ Birthdate (MM/DD/YYYY) __ / __ / ____

Employee: Last Name, First Name ____

Effective Date __ / __ / 2 0 __ Employee or HDS ID Number ____ Birthdate (MM/DD/YYYY) __ / __ / ____

Employee: Last Name, First Name ____

Effective Date __ / __ / 2 0 __ Employee or HDS ID Number ____ Birthdate (MM/DD/YYYY) __ / __ / ____

Employee: Last Name, First Name ____

Effective Date __ / __ / 2 0 __ 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