Termination/Involuntary Loss of Coverage

Mail or fax this form to:
BIC, P.O. Box 24100, Greenville, SC 292616
Fax (866) 820-3902

When Terminating All Benefits:

Company Representative must:

- Complete Sections 1, 2, 3 and sign and date Section 4.
- Submit completed form to BIC within five days of employee termination.

Questions? Call BIC customer service at (800) 497-4856

Section 1.

Employee's Name: _____ SSN: _____
Last First Middle

Address: _____
Street City State ZIP

Group Number: _____ Effective Date of Termination: _____
(The effective date of termination is the last day of the pay period for which premiums were deducted.)

Section 2. Reason for Termination (Check one and enter the date requested.)

☐ Termination of Employment
Last Day Worked: _____

☐ Death of Employee
Date of Death: _____

☐ Reduction of hours
Last Day Worked: _____

☐ Loss of Dependent Coverage
Date of Coverage Loss: _____

☐ Divorce/Legal Separation
Date of Divorce/Separation: _____

Section 3. List all family members to be cancelled

Dependent Names (First and Last)	Address (if different from address above)			
Name	Street	City	State	ZIP
Name	Street	City	State	ZIP
Name	Street	City	State	ZIP
Name	Street	City	State	ZIP

Section 4.

Authorized Company Representative: _____ Date: _____

Please print name: _____ Telephone: _____
(Please include area code.)

BENEFITS IN A CARD

Companion Life

Plans are underwritten by Companion Life Insurance Company, Columbia, South Carolina.