AMERICAN DENTAL PLAN OF WISCONSIN, INC.

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TERMINATION NOTIFICATION

Part A (All applicants)

Subscriber: Last Name	First Name	Mid. Init.	Subscriber #

Group Name:	Group Number:

Reason for Termination

Last Day of Full-Time Employment

Part B (To terminate)

Effective Date of Termination

Approved by (Group Administrator)	Date

ONCE ENROLLED, MAY NOT DISENROLL UNTIL ANNUAL CONTRACT DATE, REGARDLESS OF EMPLOYER/EMPLOYEE PREMIUM CONTRIBUTION. MAY NOT RE-ENROLL FOR TWO YEARS.