CO power | Benefits made easy
An Amwins Company

Group Cancellation Form

This form is to be completed by the Benefits Administrator. Please complete the form and submit to CoPower via E-mail at copower.requests@amwins.com or via fax at **650.348.1149 BEFORE** the effective date. Please check your plan contract for details on plan cancellation notification requirements. If information is not received as requested, CoPower cannot be held responsible for any processing delay or charges.

Group Cancellation Information

Group Name: CoPower ID Number:

Group Benefit Administrator: Contact Phone Number: - -

Contact E-Mail: Cancellation Effective Date: / /

Request to cancel the following (Check one):

☐ Dental ☐ Vision ☐ Life ☐ Long Term Disability ☐ Chiropractor/Acupuncture ☐ ALL

Changing Coverage

Change of Carrier Coverage

☐ Changed to Other Ancillary Carrier

☐ Changed to Medical Carrier's ancillary plans

☐ Changed to Ancillary Carrier Direct Name of Carrier:

☐ Coverage No Longer Needed

Reason for Cancellation / Charging Coverage (Check all that apply)

☐ Acquisition, Merger, or Company Sold

☐ Cutting Cost

☐ Bankruptcy/Closure

☐ Company Relocated Out of State

☐ Downgraded Benefits to Lower Cost

☐ Change to Voluntary Plan

☐ Need Richer Benefits

☐ Prices/Rates

☐ Administration Fee

☐ Member Out-Of-Pocket Cost High

☐ CoPower Services

☐ Plan Provider Network

Benefit Administrator Signature

Signature: _____ Date: / /

Benefit Administrator Name:

Survey

In our efforts to improve our service quality and meet the needs and expectations of our customers, we would greatly appreciate your feedback by completing this short survey:

Service Review			Service Rating (1-10) (10 = Highest Rating)
Would you consider doing business with CoPower in the future?	☐ Yes	☐ No	
Did our service meet your expectations?	☐ Yes	☐ No	
Would you recommend CoPower?	☐ Yes	☐ No	
Any suggestions for improving our services?			

Thank you for your business. CoPower is pleased to have served you!

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