Rayant Insurance Company of New York
Rayant Insurance Company of Pennsylvania
Horizon Companies

TRANSMITTAL OF DELETIONS

DELETIONS SHOULD BE SUBMITTED BY THE EFFECTIVE DATE BEING REQUESTED.

Send Correspondence to:
Rayant - Dental Programs
P.O. Box 1938
Newark, NJ 07101-1938
www.rayant.com

IMPORTANT: ALL ITEMS ON THIS SHEET MUST BE FILLED OUT ACCORDING TO INSTRUCTIONS.

I. GROUP NO. ______________________ 2. GROUP NAME ______________________ 3. DATE ____________ 20 _____

4. PAGE ________ OF ________

5. Enter IDENTIFICATION NO. Note: If the subscriber is deleted before the issuance of an IDENTIFICATION NO., enter Date of Birth	6. Enter NAME OF SUBSCRIBER to be deleted. NOTE: Report on this form subscribers cancelled from the group for left employment, requested cancellation, military service or death. LAST	FIRST	M.I.	7. REASON FOR DELETION 387 - Death 388 - Transfer to your related subgroups by Application. (No left-group billing requested) 391 - Left employment (left-group billing requested) ENTER PROPER CODE NO.	8. Enter SUBSCRIBER'S HOME ADDRESS - street address on upper line, city, state and zip code on lower line. NOTE: Failure to supply the Plan with the correct home address, including zip code, will prevent receipt of an individual bill by the subscriber.	ZIP CODE	9. EFFECTIVE DATE OF DELETIONS Enter Group Coverage Date following Date of Termination (If not submitted timely, we reserve the right to assign deletion date in accordance with plan regulations). MO.	DAY	YEAR	10. PREVIOUSLY REPORTED as deleted? If so, enter Yes and also enter date mailed. Leave blank if being reported for the first time.

IDENTIFICATION NUMBER OR SEQUENCE NUMBER AS IT APPEARS ON THE GROUP BILL.

IMPORTANT: Retain yellow for your files.
Forward white to address above.

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