TERMINATION OF DEPENDENT COVERAGE

PacificSource
HEALTH PLANS

GROUP NAME	GROUP NUMBER
EMPLOYEE NAME	PACIFICSOURCE MEMBER ID

Effective _____ *(date),* I wish to terminate PacificSource group health coverage for my family member(s) listed below:

Name			Coverage to Terminate	Reason
LAST	FIRST	INITIAL	☐All health plan coverage ☐Medical only ☐Dental only	☐Divorce ☐Retirement ☐Other
LAST	FIRST	INITIAL	☐All health plan coverage ☐Medical only ☐Dental only	☐Divorce ☐Retirement ☐Other
LAST	FIRST	INITIAL	☐All health plan coverage ☐Medical only ☐Dental only	☐Divorce ☐Retirement ☐Other
LAST	FIRST	INITIAL	☐All health plan coverage ☐Medical only ☐Dental only	☐Divorce ☐Retirement ☐Other
LAST	FIRST	INITIAL	☐All health plan coverage ☐Medical only ☐Dental only	☐Divorce ☐Retirement ☐Other

I understand that, should I wish to re-enroll these family members at a later date, they could be subject to waiting periods for coverage.

_____   _____
Employee Signature   Date