

**TERMINATION
OF DEPENDENT
COVERAGE**



PO Box 7068
Eugene, Oregon 97401
(541) 686-1242 • 800-624-6052
Fax (541) 683-8328

GROUP NAME	GROUP NO.
EMPLOYEE NAME	SOCIAL SECURITY NO.

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

NAME - LAST	FIRST	INITIAL	SOCIAL SECURITY NO.	REASON

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

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