TERMINATION OF DEPENDENT COVERAGE

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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