

**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	<input type="checkbox"/> All health plan coverage <input type="checkbox"/> Medical only <input type="checkbox"/> Dental only	<input type="checkbox"/> Divorce <input type="checkbox"/> Retirement <input type="checkbox"/> Other
LAST	FIRST	INITIAL	<input type="checkbox"/> All health plan coverage <input type="checkbox"/> Medical only <input type="checkbox"/> Dental only	<input type="checkbox"/> Divorce <input type="checkbox"/> Retirement <input type="checkbox"/> Other
LAST	FIRST	INITIAL	<input type="checkbox"/> All health plan coverage <input type="checkbox"/> Medical only <input type="checkbox"/> Dental only	<input type="checkbox"/> Divorce <input type="checkbox"/> Retirement <input type="checkbox"/> Other
LAST	FIRST	INITIAL	<input type="checkbox"/> All health plan coverage <input type="checkbox"/> Medical only <input type="checkbox"/> Dental only	<input type="checkbox"/> Divorce <input type="checkbox"/> Retirement <input type="checkbox"/> Other
LAST	FIRST	INITIAL	<input type="checkbox"/> All health plan coverage <input type="checkbox"/> Medical only <input type="checkbox"/> Dental only	<input type="checkbox"/> Divorce <input type="checkbox"/> Retirement <input type="checkbox"/> 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